PATIENT REGISTRATION FORM
Crown Heights Psychological Services, PLLC
Living Wellness Center
201 Eastern Parkway, Suite 1A
Brooklyn, NY 11238

Today's Date

PATIENT INFORMATION

Patient's Last Name	First	Middle	Mr. \ Mrs. \ Ms.	Marital Status: Single \ Married \ Divorced \ Widowed

Is this your legal name? ☐Yes☐No	If not, what is your legal Name?	Former Name	Birth Date	Age	Sex

Street Address	Apt. No.	Home Phone Number

City	State	Zipcode

Occupation	Employer	Employer Phone Number

Do you have a Primary Care Doctor? ☐Yes ☐No

Name of PCP or Medical Doctor	Address	Telephone Number

INSURANCE INFORMATION

Person Responsible for Bill	Birth Date	Address (if different)	Home Phone Number

Is the patient covered by insurance? ☐Yes ☐No

Name of Insurance Company

Subscriber's Name	Subscriber's Social Security Number	Birth Date	Group Number	Member ID Number	Copay

Patient's Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other

IN CASE OF EMERGENCY

Name of friend or relative (not living at same address)	Relationship to patient	Home phone number	Alternative phone number

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Dr. Roy Jerome and Crown Heights Psycholocial Services, PLLC. I understand that I am finacially responsible for my balance. I also authorize Dr. Roy Jerome and Crown Heights Psychological Services, PLLC or my insurance company to release any information required to process my claim.

Signature of Patient/Guardian Signature

Date

Cancellation, Rescheduling, and Insurance Payment Policies

Excessive cancellations should be avoided because keeping therapy appointments on a consistent basis is essential to making meaningful progress.

If you and I decide to work together, I will schedule one fifty-minute session (one appointment hour of fifty minutes duration) per week at a mutually agreed time. Once this appointment hour is scheduled, you will be expected to pay for it. If you are unable to make your scheduled appointment, you are asked to contact me at least 48 hours ahead of time to cancel your appointment. If you are unable to do so, you will be charged for your appointment. Unfortunately, your insurance will not pay for missed therapy sessions. As such, if you are unable to call and cancel at least 48 hours ahead of time, you will be charged my full rate of $160 per session.

I know that sometimes emergency situations arise which necessitate rescheduling your weekly appointment. I would appreciate a phone call 48 hours ahead of time in order to reschedule. If possible, I will work with you to reschedule appointment for a new time that week

In instances where your insurance company limits the number of sessions covered per year, you will be responsible for payment of sessions that exceed such limitations.

You will be required to keep a credit card on file and to provide signed authorization that this card may be charged for absences and sessions that exceed insurance limitations.

You will be responsible for updating your credit card information whenever it may change.
In situations where a client shows a pattern of excessive cancellations and efforts to address the situations are unsuccessful, the client may lose their reserved appointment hour. Such situations are rare and are usually resolved successfully.

I have read this document detailing cancellation, rescheduling, and insurance policies. I have had the opportunity to ask questions and discuss my concerns regarding these policies. My questions have been answered and I have been provided a copy of this form.

Client Name:______________________ Therapist Name:__________________

Client Signature:___________________ Therapist Signature:_______________

Date:_____________________________ Date:___________________________

Credit/Debit Card Payment Consent Form

Patient Name ____
Print Last *First* *Middle Initial*

Name on Card if different ______________________________________

I authorize Roy Jerome ______________, ***and ProfessionalCharges.com***,
to charge my credit/debit card for professional services as follows:

Initial

_______ This visit only, for the amount of $ ______________ .

_______ All visits in the next 12 months, beginning _____ /_____ /_____,

not to exceed $ ___________ total.

_______ Recurring charges, date(s) of service _____ /_____ /_____ to

_____ /_____ /_____, not to exceed $ _______________,

____ monthly, ____ semimonthly, ____ weekly, ____ per visit.

Initial here ⇒ _______ **To charge my card for the balance of fees not paid by my insurance company within 90 days, as indicated above.**

Type of Card: ☐ Visa, ☐ MasterCard, ☐ Discover.

Card Number _______ - _______ - _______ - _______,

CVV Number _________
A 3-digit number in reverse italics on the **back** of the credit card

Expiration Date _____________

Card Holder's Billing Address for Credit Card Statements

____
Street *City* *State* *Zip*

If I have questions about these charges, I agree to contact my provider and if necessary ProfessionalCharges.com via email (info@professionalcharges.com). I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.

Card Holder Signature ________________________________, Date ____ /_____ /____

Charges will appear on your credit card statement as an abbreviation of
ProfessionalCharges.com.

1530 E. Chevy Chase Dr., Ste. 209
Glendale, CA 91206

E-mail: Info@ProfessionalCharges.com

INTAKE FORM

Today's Date ______________

Name ___________________________________ Gender ____________
Date of Birth __________

Street address:
____

City ______________________________ State ______________ZIP ________________

Home/evening phone: ____________________________ e-mail:____________________
Calls or e-mail will be discreet, but please indicate any restrictions:
____

Referred by
____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No
How did this person explain how I might be of help to you?
____

Person to contact in an emergency _________________________ Phone (___)-____________
Address ____
Relationship to you ____________________

Persons with whom you live and their relationship to you:
____
____

Children: NO _____ YES____ (Please answer below)
Name ____________________ Age ___________
____________________ ___________
____________________ ___________

Your Occupation or work emphasis _______________________________
Years of Education ____
Education major or training emphasis____
Employer______________________________________ Years worked there ____________

Marital status (i.e. single, married, separated, divorced, living with partner) ________
Spouse/partner name ___________________________
Spouse/partner occupation _________________

Religious and racial/ethnic identification
Current religious denomination/affiliation ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic

❑ Buddhist ❑ Hindu
Other (specify): ___________________________________
Involvement: ❑ None ❑ Some/irregular ❑ Active
How important are spiritual concerns in your life?

____

Which (if any) church, synagogue, temple, or meeting are you involved with?_______________

Ethnicity/national origin: ______________________________
Race: _________________________ or other similar way you identify yourself and consider important: ____

Outpatient Medical Record - Please check all those that have occurred at any time.

Head injury___ Learning Problems ___
Alcoholism___ Substance Abuse___Hepatitis___ Chicken Pox___ Rheumatic Fever__Thyroid Problems__ Whooping Cough__
Hernia___Cancer/Tumor___ Poliomyelitis___ Sinus Problems____ Food Intolerance___Speech Problems__ Epilepsy___ Bronchitis___
Measles___ Scarlet Fever___Typhoid Fever___ Hearing Problems___
Asthma___Mumps___Bulimia/Anorexia___ Tuberculoses___
Special Diets___ STD___ Appendicitis___ Hypertension___ Stroke___ Anemia___ Kidney Disease___ Diabetes___ Smallpox___
Tonsillitis___ Pregnancies___Heart Palpitations___ Pneumonia___ Neurological disease________Other

____

Gastrointestinal problems: __________________________Significant weight loss/gain

____

Allergies (food, drug, other: please list)_________________________ HIV Positive? Yes ____ No ____ How Long? _________
Do you experience any of the following? Abdominal Pain_______ Changes in Appetite_______
Dizziness_______Bed Wetting_________ Headaches______________
Fatigue_________Frequent Urination_____ Fainting Spells___________ Chest Pain______
BreathingProblems_______Nausea_________Colds______Nosebleeds____Constipation_____
Sore throat___________ Coughs______________ Toothache_______ Menstrual Problems____
Diarrhea_____________
Vomiting______ ______ Ear Infection_____ Eye Vision Problems___ Memory Problems ____

List any operations, Medical Procedures or Hospitalizations for medical, psychiatric/emotional, drug or alcohol problems. Please include Dates.

____

____

Prescription drugs taken currently or in the past 6 months:
Prescription drug name Reason Prescribed Frequency/dosage

___________________ ___________________ ___________________

Note any of the side effects of adverse reactions to medications listed above:

Legal Status i.e. Are you currently involved with the criminal justice system?

____

Chemical use
How many cups of regular coffee do you drink each day? _____
How many cups of tea? ____
How many sodas with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, etc.)? ____
How many "energy drinks"? ____
How often do you use No Doz or similar caffeine pills? _______ .
How much tobacco do you smoke or chew each week? _________________________________
Have you ever felt the need to cut down on your drinking? ❑ No ❑ Yes
Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes
Have you ever felt guilty about your drinking? ❑ No ❑ Yes
Have you ever taken a morning "eye-opener"? ❑ No ❑ Yes
How much beer, wine, or hard liquor do you consume each week, on the average?

____

Are there times when you drink to unconsciousness, or run out of money as a result of drinking?
❑ No ❑ Yes
Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? ❑ No ❑ Yes
If yes, which and when?

____

Which drugs (not medications prescribed for you) have you used in the last 10 years?

____

____

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth:

____

Please help me understand what problems brought you to this office.
Check all that apply: Marital___ Job___ Career_____ School___ Alcohol___ Substance Abuse___ Depression___ Moodiness__ Self Confidence___ illness___ Fatigue___ Psychological___ Children___ Family___ Sexual Problems___ Traumatic Experience___ Loneliness___
Other or elaborate on above

____

Are you currently having any suicidal ideation?____

Previous Counseling or Psychotherapy? (please designate when, where, with whom and whether it was as a child, adult, couple or court ordered)

Dates of Therapy	Place	Reason You Sought Out Therapy	Did You Find it Helpful?

Previous contact with psychiatrist for medication, or psychologist for psychological evaluation:
YES ____ NO_____

____

Is there any other information you think we should know?

____

____

Patient's signature_______________________________ Date ____/____/_______

Patient's Name (printed)___________________________________

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to my practice. I appreciate your giving me the opportunity to be of help to you. This document answers questions that clients often ask about therapy. I believe our work will be most helpful to you when you have a clear idea of what we are trying to do. This document also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a *Notice of Privacy Practices* (the *Notice*) for use and disclosure of PHI for treatment, payment, and health care operations. The *Notice*, which accompanies this *Agreement*, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. This Agreement talks about the following:

- What the risks and benefits of therapy are.
- What the goals of therapy are and what my methods of treatment are like.
- How long therapy might take.
- How much my services cost, and how I handle money matters.
- Important information about HIPAA and protection of your privacy
- Other important areas of our relationship.

After you read this document, we can talk in person about how these issues apply to you.
This document is yours to keep. Please read all of it. Mark any parts that are not clear to you. Write down any questions you have, and we will discuss them at our next meeting. When you have read and fully understood this *Agreement*, I will ask you to sign two copies. I will sign the two copies, so we each have one. When you sign this document, it will also represent an agreement between us.

About Psychotherapy

I strongly believe you should feel comfortable with the therapist you choose, and hopeful about the therapy. When you feel this way, therapy is more likely to be very helpful to you. Let me describe how I see therapy. I trained as a generalist psychologist providing treatment across the lifespan and adult life. I generally do not provide services for young children and adolescents, but would gladly refer you to colleagues who do specialize with young children. My theoretical orientation is relational and rooted in psychodynamic traditions. I also incorporate cognitive-behavioral as well as evidence-based approaches to address particular problems.

I might occasionally take notes during our meetings, especially during initial sessions. You may find it useful to take your own notes, and also to take notes outside the office.

By the end of our first or second session, I will tell you how I see your case at this point and how I think we should proceed. I view therapy as a partnership between us. You define the problem areas to be worked on; I use my professional knowledge to help you make the changes you want

to make. Psychotherapy is not like visiting a medical doctor. It requires your very active involvement. It requires your best efforts to change thoughts, feelings, and behaviors. For example, I want you to tell me about important experiences, what they mean to you, and what strong feelings are involved. This is one of the ways you are an active partner in therapy. I expect us to plan our work together. In our treatment plan, we will list the areas to work on, our goals, the methods we will use, the time and money commitments we will make, and any other information important to our planned work together. I expect us to agree on a plan that we will both work hard to follow. From time to time, we will look together at our progress and goals. If we think we need to, we can then change our treatment plan, its goals, or its methods. An important part of your therapy will be practicing new skills that you will learn in our sessions. I will ask you to practice outside our meetings, and we may work together to set up homework assignments for you. I might ask you to do exercises, keep records, and read to deepen your learning. You will probably have to work on relationships in your life and make long-term efforts to get the best results. These are important parts of personal change. Change will sometimes be easy and quick, but more often it will be slow and frustrating, and you will need to keep trying. There are no instant, painless cures and no "magic pills." However, you can learn new ways of looking at your problems that will be very helpful for changing your feelings and reactions.

Depending on our agreed upon goals for treatment, treatment may be long or short term. The process of ending therapy, called "termination," can be a very valuable part of our work. Stopping therapy should not be done casually, although either of us may decide to end it if we believe it is in your best interest. If you wish to stop therapy at any time, I ask that you agree now to meet then for at least one more session to review our work together. We will review our goals, the work we have done, any future work that needs to be done, and our choices. If you would like to take a "time out" from therapy to try it on your own, we should discuss this. We can often make such a "time out" be more helpful.

The Benefits and Risks of Therapy

As with any treatment, there are some risks as well as many benefits with therapy. You should think about both the benefits and risks when making any treatment decisions. For example, in therapy, there is a risk that clients will, for a time, have uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other negative feelings. Clients may recall unpleasant memories. These feelings or memories may bother a client at work or in school. In addition, some people in the community may mistakenly view anyone in therapy as weak, or perhaps as disturbed. Also, clients in therapy may have problems with people important to them. Family secrets may be told. Therapy may disrupt a marital relationship and sometimes may even lead to a divorce. Sometimes, too, a client's problems may temporarily worsen after the beginning of treatment. Most of these risks are to be expected when people are making important changes in their lives. Finally, even with our best efforts, there is a risk that therapy may not work out well for you.

While you consider these risks, you should know also that therapy can be very beneficial. Many people report improvement in their presenting problems and the benefits of therapy have been supported by empirical research in hundreds of well-designed research studies. People who are depressed may find their mood lifting. Others may no longer feel afraid, angry, or anxious. In therapy, people have a chance to talk things out fully until their feelings are relieved or the

problems are solved. Clients' relationships and coping skills may improve greatly. They may get more satisfaction out of social and family relationships. Their personal goals and values may become clearer. They may grow in many directions—as persons, in their close relationships, in their work or schooling, and in the ability to enjoy their lives. I do not take on clients I do not think I can help. Therefore, I will enter our relationship with optimism about our progress.

Consultations
If you could benefit from a treatment I cannot provide, I will help you to get it. You have a right to ask me about such other treatments, their risks, and their benefits. Based on what I learn about your problems, I may recommend a medical exam or use of medication. If I do this, I will fully discuss my reasons with you, so that you can decide what is best. If you are treated by another professional, I will coordinate my services with them and with your own medical doctor.

If for some reason treatment is not going well, I might suggest you see another therapist or another professional for an evaluation. As a responsible person and ethical therapist, I cannot continue to treat you if my treatment is not working for you. If you wish for another professional's opinion at any time, or wish to talk with another therapist, I will help you find a qualified person and will provide him or her with the information needed (with your written permission to share this information as detailed below).

What to Expect from Our Relationship
As a professional, I will use my best knowledge and skills to help you. This includes following the standards of the American Psychological Association, or APA. In your best interests, the APA puts limits on the relationship between a therapist and a client, and I will abide by these. Let me explain these limits, so you will not think they are personal responses to you.

First, I am licensed and trained to practice psychology—not law, medicine, finance, or any other profession. I am not able to give you good advice from these other professional viewpoints.

Second, state laws and the rules of the APA require me to keep what you tell me confidential (that is, just between us). You can trust me not to tell anyone else what you tell me, except in certain limited situations. I explain what those are in the "About Confidentiality" section of this Agreement. Here, I want to explain that I try not to reveal who my clients are. This is part of my effort to maintain your privacy. If we meet on the street or socially, I may not say hello or talk to you very much. My behavior will not be a personal reaction to you, but a way to maintain the confidentiality of our relationship.

Third, in your best interest, and following the APA's standards, I can only be your therapist. I cannot have any other role in your life. I cannot, now or ever, be a close friend to or socialize with any of my clients. I cannot be a therapist to someone who is already a friend. I can never have a sexual or romantic relationship with any client during, or after, the course of therapy. I cannot have a business relationship with any of my clients, other than the therapy relationship.

If you ever become involved in a divorce or custody dispute, I want you to understand and agree that I will not provide evaluations or expert testimony in court. You should hire a different mental health professional for any evaluations or testimony you require. This position is based on two

reasons: (1) My statements will be seen as biased in your favor because we have a therapy relationship; and (2) the testimony might affect our therapy relationship, and I must put this relationship first.

Even though you might invite me, I will not attend your family gatherings, such as parties or weddings.

About Confidentiality

I will treat with great care all the information you share with me. It is your legal right that our sessions and my records about you be kept private. The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written *Authorization Form* that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my *Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information*).

- I also have a contract with *Office Ally*, which I use to process insurance claims. As required by HIPAA, I have a formal business associate contract with this business, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with a blank copy of this contract.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services that I provided you, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

- If I am providing treatment for conditions directly related to worker's compensation claim, I may have to submit such records, upon appropriate request, to Chairman of the Worker's Compensation Board on such forms and at such times as the chairman may require.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I receive information in my professional capacity from a child or the parents or guardian or other custodian of a child that that gives me reasonable cause to suspect that a child is an abused or neglected child, the law requires that I report to the appropriate governmental agency, usually the statewide central register of child abuse and maltreatment, or the local child protective services office. Once such a report is filed, I may be required to provide additional information.

- If a patient communicates an immediate threat of serious physical harm to an identifiable victim, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

Finally, it may be beneficial for me to confer with your primary care physician with regard to your psychological treatment or to discuss any medical problems for which you are receiving treatment. In addition, Medicare requires that I notify your physician by telephone or in writing, concerning services that are being provided by me unless you request that notification not be made.

Please check only ONE of the following:
__ I authorize you to contact my primary care physician whose name and address are shown below to discuss the treatment that I am receiving while under your care and to obtain information concerning my medical diagnosis and treatment.
__ I do not authorize you to contact my primary care physician with regard to the treatment that I am receiving while under your care or to obtain information concerning my medical diagnosis and treatment. I am providing you with the name and address of my primary care physician only for your records.

Please write below the name, address, and phone number of your primary physician:

Name______________________________________ Phone______________________________
Address____

Except for situations like those I have described above, I will always maintain your privacy. I also ask you not to disclose the name or identity of any other client being seen in this office. I make every effort to keep the names and records of clients private. I will try never to use your name on the telephone, if clients in the office can overhear it. If your records need to be seen by another professional, or anyone else, I will discuss it with you. If you agree to share these records, you will need to sign an *Authorization Form*. This form states exactly what information is to be shared, with whom, and why, and it also sets time limits. You may read this form at any time. If you have questions, please ask me.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Professional Records

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your Clinical Record at any time. You may add to them or correct them and you can have copies of them. If you would like examine or have a copy of your Clinical Record, you may simply provide me with a request in writing. If you request to examine, or have a copy of your records, or have a copy of your records forwarded to another mental health professional, I would like to recommend that we initially review your records together. Reviewing your records together will provide you with more understanding of your records and help you gain a greater understanding of your treatment. If you request I copy your files, I may charge a copying fee of 75 cents per page (and for certain other expenses). If I refuse your request for access to your records, you have a right to of review, which I will discuss with you upon request.

In some very rare situations, I may temporarily remove parts of your records before you see them. This would happen if I believe that the information will be harmful to you, but I will discuss this with you. You have the right to ask that your information not be shared with family members or others, and I can agree to that limitation. You can also tell me if you want me to send mail or phone you at a more private address or number than, say, your home or workplace. If this is of concern to you, please tell me so that we can make arrangements.

It is my office policy to destroy clients' records 7 years after the end of our therapy. Until then, I will keep your case records in a safe place.

Computerized records are kept in encrypted files, backed up to an encrypted system to help ensure confidentiality.

If I must discontinue our relationship because of illness, disability, or other presently unforeseen circumstances, I ask you to agree to my transferring your records to another therapist who will assure their confidentiality, preservation, and appropriate access.

As part of cost control efforts, an insurance company will sometimes ask for more information on symptoms, diagnoses, and my treatment methods. It will become part of your permanent medical record. I will let you know if this should occur and what the company has asked for. Please understand that I have no control over how these records are handled at the insurance company. My policy is to provide only as much information as the insurance company will need to pay your benefits.

Patient Rights
HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

Minors and Parents
Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Even where parental consent is given, children over age 12 may have the right to control access to their treatment records. While privacy in psychotherapy is very important, particularly with teenagers, parental involvement is also essential to successful treatment, particularly with younger children. For children age 12 and over, I request an agreement between my patient and his/her parents allowing me to share general information about the progress of the child's treatment and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

My Background
I am a psychologist licensed in New York State. I am trained and experienced in doing one-on-one, group therapy and couple therapy with adults (18 years and over). Earlier in my career, I worked in VA Medical Centers, in an inpatient psychiatric treatment center, substance abuse treatment programs, and mental health clinics. I hold these qualifications:

_ I have a doctoral degree in Counseling Psychology from New York University, whose program is approved by the American Psychological Association (APA).
_ I completed an internship in clinical psychology, approved by the APA.
_ I am licensed as a psychologist in New York (#019645).
_ I am a member of the APA.
_ I am a member of the New York State Psychological Association.

About Our Appointments
The very first time I meet with you, we will need to give each other much basic information. For this reason, I usually schedule 1 hour for this first meeting. Following this, we will usually meet

for a 50-minute session once or twice a week. We can schedule meetings at both your and my convenience. I will tell you at least a month in advance of my vacations or any other times we cannot meet. Please ask about my schedule in making your own plans.

An appointment is a commitment to our work. We agree to meet here and to be on time. If I am ever unable to start on time, I ask for your understanding. I also assure you that you will receive the full time agreed to. If you are late, we will probably be unable to meet for the full time, because it is likely that I will have another appointment after yours. A cancelled appointment delays our work. I will consider our meetings very important and ask you to do the same. Please try not to miss sessions if you can possibly help it. When you must cancel, please give me at least a week's notice. Your session time is reserved for you. I am rarely able to fill a cancelled session unless I know a week in advance. If you start to cancel sessions, I will have to charge you for the lost time unless I am able to fill it. Your insurance will not cover this charge. I will reserve a regular appointment time for you into the foreseeable future. I also do this for my other patients. Therefore, I am rarely able to fill a cancelled session unless I have several weeks' notice. You will be charged the full fee for sessions cancelled with less than 48 hours' notice, for other than the most serious reasons.

I request that you do not bring children with you if they are young and need babysitting or supervision, which I cannot provide. I cannot be responsible for any personal property or valuables you bring into this office.

Fees

Payment for services is an important part of any professional relationship. One treatment goal is to make relationships and the duties and obligations they involve clear. You are responsible for seeing that my services are paid for.

My current regular fees are as follows. All fees are due at the time of service. Credit cards, checks, or cash are all acceptable forms of payment. I charge a standard fee of $160 per individual session and $180 for couples' therapy. Individual sessions run typically from 45 to 50 minutes, couples' sessions for 60 minutes. Alternative fee arrangements can be discussed at the initial consultation if cost is a barrier to you.

Telephone consultations: I believe that telephone consultations may be suitable or even needed at times in our therapy. If so, I will charge you our regular fee, prorated over the time needed. If I need to have long telephone conferences with other professionals as part of your treatment, you will be billed for these at the same rate as for regular therapy services. If you are concerned about this, please be sure to discuss it with me in advance so we can set a policy that is comfortable for both of us. Of course, there is no charge for calls or email messages about appointments or similar business.

Extended sessions: Occasionally it may be better to go on with a session, rather than stop or postpone work on a particular issue. When this extension is more than 10 minutes, I will tell you, because sessions that are extended beyond 10 minutes will be charged on a prorated basis.

Reports: I will not charge you for my time spent making routine reports to your insurance company. However, I will have to bill you for any extra-long or complex reports the company might require. The company will not cover this fee.

Other services: I realize that my fees involve a substantial amount of money, although they are well in line with similar professionals' charges. For you to get the best value for your money, we must work hard and well. I will assume that our agreed-upon fee-paying relationship will continue as long as I provide services to you. I will assume this until you tell me in person, by telephone, or by certified mail that you wish to end it. You have a responsibility to pay for any services you receive before you end the relationship.

Billing
Because I expect all payment at the time of our meetings, I usually do not send bills. However, if we have agreed that I will bill you, I ask that the bill be paid within 5 days of when you get it. At the end of each month, I will give you a statement if you request one. The statement can be used for health insurance claims, as described in the next section. It will show all of our meetings, the charges for each, how much has been paid, and how much (if any) is still owed. At the end of treatment, and when you have paid for all sessions, I will send you a final statement for your tax records if you would like (simply provide me with a request in writing).

Payments
Please pay for each session before our session or at its end. I have found that this arrangement helps us stay focused on our goals, and so it works best. It also allows me to keep my fees as low as possible, because it cuts down on my bookkeeping costs. I suggest you make out your check before each session begins, so that our time will be used best. Other payment or fee arrangements must be worked out before the end of our first meeting.

In order to help you make payment for services, I employ *Professionalcharges.com*, an online credit card processing company designed for practitioners like myself. *Professionalcharges.com* offers an easy, safe, and secure online method for making payments for services. To make payment for services, you may go to my website, *www.royjeromephd.com* which details how you may make online payments for services (ex., weekly copayments, payment for session, or other unpaid balances).

In connection with our work together, you will be asked to sign a *Credit/Debit Card Payment Consent Form* at our first meeting. This consent form also asks you for credit card information. This information is kept on file in order to facilitate your payment for sessions and for other unpaid balances. In addition, you will be asked to sign a *Cancellation, Rescheduling, and Insurance Payment Policies* form, which also details important payment policies. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of charging your credit card on file. Before I do so, I will contact you by telephone as well as by US mail to discuss payment, your account balance, as well as a possible payment plan.

If your unpaid balance reaches $600, I will notify you by mail. If it then remains unpaid, I must stop therapy with you. If there is any problem with my charges, my billing, your insurance, or any

other money-related point, please bring it to my attention. I will do the same with you. Such problems can interfere greatly with our work. They must be worked out openly and quickly.

Depending on your financial circumstances and total medical costs for any year, psychotherapy may be a deductible expense; consult your tax advisor. Cost of transportation to and from appointments and fees paid may be deductible from the client's personal income taxes as medical expenses. If you think you may have trouble paying your bills on time, please discuss this with me. I will also raise the matter with you so we can arrive at a solution.

Insurance Reimbursement

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

Because health insurance is written by many different companies, I cannot tell you what your plan covers. Please read your plan's booklet under coverage for "Outpatient Psychotherapy" or under "Treatment of Mental Conditions." Or call your employer's benefits office to find out what you need to know. If your health insurance will pay part of my fee, I will help you with your insurance claim forms. However, please keep two things in mind:

1. I had no role in deciding what your insurance covers. Your employer decided which, if any, services will be covered and how much you have to pay. You are responsible for checking your insurance coverage, deductibles, payment rates, copayments, and so forth. Your insurance contract is between you and your company; it is not between me and the insurance company.

2. You—not your insurance company or any other person or company—are responsible for paying the fees we agree upon. If you ask me to bill a separated spouse, a relative, or an insurance company, and I do not receive payment on time, I will then expect this payment from you.

If You Have a Managed Care Contract

If you belong to a health maintenance organization (HMO) or preferred provider organization (PPO), or have another kind of health insurance with managed care, decisions about what kind of care you need and how much of it you can receive will be reviewed by the plan. The plan has rules, limits, and procedures that we should discuss. Please bring your health insurance plan's description of services to one of our early meetings, so that we can talk about it and decide what to do. I will provide information about you to your insurance company only with your informed and written consent. I may send this information by mail or by fax. I will try my best to maintain the privacy of your records, but I ask you not to hold me responsible for accidents or for anything that happens as a result. Insurance is a contract between you (or your employer) and your insurer; I am not part of that contract. However, I will supply you with an invoice for my services with the standard diagnostic and procedure codes for billing purposes, the times we met, my charges, and your payments. You can use this to apply for reimbursement.

If You Need to Contact Me

I cannot promise that I will be available at all times. I usually do not take phone calls when I am with a client. You can always leave a message on my voicemail, and I will return your call as soon as I can. Generally, I will return voicemail and e-mail messages daily between 9am and 8pm, except on Sundays and holidays. If you have a behavioral or emotional crisis and cannot reach me immediately by telephone, you or your family members should call one of the following community emergency agencies: 1-800-LIFENET; 911; or go to the nearest hospital emergency room.

If I Need to Contact Someone about You

If there is an emergency during our work together, or I become concerned about your personal safety, I am required by law and by the rules of my profession to contact someone close to you—perhaps a relative, spouse, or close friend. I am also required to contact this person, or the authorities, if I become concerned about your harming someone else. Please write down the name and information of your chosen contact person in the blanks provided:

Name____ Phone__________________________

Address____

Relationship to you____

Other Points

As a professional therapist, I naturally want to know more about how therapy helps people. To understand therapy better, I must collect information about clients before, during, and after therapy. Therefore, I am asking you to help me by filling out some questionnaires about different parts of your life-relationships, changes, concerns, attitudes, and other areas. I ask your permission to take what you write on these questionnaires and what I have in my records and use it in research or teaching that I may do in the future. If I ever use the information from your questionnaire, it will always be included with information from many others. Also, your identity will be made completely anonymous. Your name will never be mentioned, and all personal information will be disguised and changed. After the research, teaching, or publishing project is completed all the data used will be destroyed. If, as part of our therapy, you create and provide to me records, notes, artworks, or any other documents or materials, I will return the originals to you at your written request but will retain copies.

Statement of Principles and Complaint Procedures

It is my intention to fully abide by all the rules of the American Psychological Association (APA) and by those of my New York State license. Problems can arise in our relationship, just as in any other relationship. If you are not satisfied with any area of our work, please raise your concerns with me at once. Our work together will be slower and harder if your concerns with me are not worked out. I will make every effort to hear any complaints you have and to seek solutions to them. If you feel that I (or any other therapist) have treated you unfairly or have even broken a professional rule, please tell me. You can also contact the state or local psychological association and speak to the chairperson of the ethics committee. He or she can help clarify your concerns or tell you how to file a complaint. You may also contact the New York State Education Department's Division of Professional Licensing Services, the organization that licenses those of us in the

independent practice of psychology. In my practice as a therapist, I do not discriminate against clients because of any of these factors: age, sex, marital/family status, race, color, religious beliefs, ethnic origin, place of residence, veteran status, physical disability, health status, sexual orientation, or criminal record unrelated to present dangerousness. This is a personal commitment, as well as being required by federal, state, and local laws and regulations. I will always take steps to advance and support the values of equal opportunity, human dignity, and racial/ethnic/ cultural diversity. If you believe you have been discriminated against, please bring this matter to my attention immediately.

Our Agreement

I, the client (or his or her parent or guardian), understand I have the right not to sign this form. My signature below indicates that I have read and discussed this agreement; it does not indicate that I am waiving any of my rights. I understand that any of the points mentioned above can be discussed and may be open to change. If at any time during the treatment I have questions about any of the subjects discussed in this Agreement, I can talk with you about them, and you will do your best to answer them. I understand that after therapy begins I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with you before ending therapy with you. I understand that no specific promises have been made to me by this therapist about the results of treatment, the effectiveness of the procedures used by this therapist, or the number of sessions necessary for therapy to be effective.

Our Agreement (Cont.)
I have read, or have had read to me, the issues and points in this Agreement. I have discussed those points I did not understand, and have had my questions, if any, fully answered. I agree to act according to the points covered in this Agreement. I hereby agree to enter into therapy with this therapist (or to have the client enter therapy), and to cooperate fully and to the best of my ability, as shown by my signature here. I have also received a copy of a *Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information.*

____
Signature of client (or person acting for client)

____
Date

____
Printed name

Relationship to client:
__Self; __Parent; __ Legal guardian; __Other person authorized to act on behalf of the client – specify: ____

I, the therapist, have met with this client (and/or his or her parent or guardian) for a suitable period of time, and have informed him or her of the issues and points raised in this Agreement. I have responded to all of his or her questions. I believe this person fully understands the issues, and I find no reason to believe this person is not fully competent to give informed consent to treatment. I agree to enter into therapy with the client, as shown by my signature here. I have also provided my client with a copy of a *Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information.*

____
Signature of therapist

____
Date

____
Printed Name of Therapist

I truly appreciate the chance you have given me to be of professional service to you, and look forward to a successful relationship with you. If you are satisfied with my services as we proceed, I (like any professional) would appreciate your referring other people to me who might also be able to make use of my services.
__Copy accepted by client __ Copy kept by therapist