ADVANCE THRU PSYCHOTHERAPY & FAMILY DEVELOPMENT, PA
RELATIONSHIP SOLUTIONS NJ

_____Tamara Sofair-Fisch, Ph.D. NJ Licensed Psychologist (#35S100165100)
_____Mark Sofair-Fisch, Ph.D., NJ Licensed Psychologist (#35S100432500)
NJ Licensed Clinical Alcohol and Drug Counselor (# 37LC00043500)

Location #1_____ **Location#2_____**
Lawrenceville, NJ 08648 **West Orange, NJ 07052**

INFORMED CONSENT

This form summarizes our business practices, to which you are agreeing. Please read carefully and ask any questions. Please initial the end of each section, indicating that you have read and understand that section. Once you are comfortable with this agreement, please sign the last page and return the form to me. Please feel free to request a copy for your records.

You have chosen to receive psychological and/or counseling services from the psychologist whose name is checked above. Your choice is voluntary and you understand that you may terminate these services at any time.

You understand that there is no assurance that you will feel better. Psychotherapy is a cooperative effort between you and Dr. Sofair-Fisch. We will work with you to resolve any difficulties in a cooperative manner, and, similarly, you agree to work with Dr, Sofair-Fisch in a cooperative manner to resolve any difficulties, as well.

You understand that during the course of your treatment, material may be discussed which will be upsetting in nature and this may be necessary to help you solve your problems.

You understand that the first session is known as a diagnostic evaluation. At this first session, we will discuss your presenting problems and complaints, history, previous therapy, medications, goals, etc. This thorough evaluation will permit Dr. Sofair-Fisch to create a treatment plan for you. Sometimes, the evaluation process takes more than one session. In all cases, the actual therapy sessions begin after the first session.

CONFIDENTIALITY

You understand that records and information collected about you will be held and released in accordance with state laws regarding confidentiality and privilege of such records and information. In general, all of your communications to us are protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issue demand it, and I must comply with that court order.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child (elderly person or disabled person) is being abused or has been physically or sexually abused, I must make a report to the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the 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. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it

with you before taking any action. To reduce the risk of harm from firearms, I am required by law to call the police where you live, if I believe there is an imminent risk of harm to you or another.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important to our work together.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice I am unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex and I am not an attorney. [If you request, I will provide you with relevant portions or summaries of the state laws regarding these issues.

Patient Initial_____ **Spouse Initial**_____

FEES

(1) Initial Psychological Evaluation	$275
(2) Marital and/or Family Psychotherapy	$250
(3) Individual Psychotherapy (90834) (38 to 45 minutes face to face)	$250
(4) Individual Psychotherapy (90837) (53 to 60 minutes face to face)	$250
(5) Family Psychotherapy without patient present (90846)	$250

Fees are structured differently for holders of Medicare and/or insurance plans with which we participate. We honor the fee structure imposed by these plans. This will be discussed at the time that we establish your initial evaluation appointment. Sometimes there is confusion as to whether or not we actually participate with your plan. It is your job to contact the insurance company and gather the details. If you have received incorrect information from the insurer, it is your job to deal with the insurance company, to rectify any errors.

TELETHERAPY

There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions. Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s). We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it. You need to use a webcam or smartphone during the session. It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session. It is important to use a secure internet connection rather than public/free Wi-Fi. It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email. We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems. We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation. If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions. You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment. As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

Patient Initial_____ **Spouse Initial**_____

INSURANCE BILLING

Insurance Requirements

If I am planning to utilize my health insurance in order to make full or partial payment for psychological services, I understand that my insurance carrier may require certain information about me, my problems and my treatment be provided to them in the form of what are most commonly termed, "Out Patient Treatment Plans." I understand that these "Treatment Plans" may be required for what is termed "Utilization Review": A process whereby **my insurance carrier** determines whether additional psychological treatment is needed. I understand that the criteria most often used to make that determination is whether continued treatment is "Medically Necessitated." In some cases, insurance carriers require "Discharge Summaries" to be submitted by the treating Psychologist at the end of treatment.

I understand that in all instances the name checked above will explain the requirements of my particular insurance carrier in this regard and obtain separate authorization from me for the release of such treatment plans.

I understand that I may refuse to release such information to my insurance carrier. However, if I do refuse, I understand that my insurance carrier will in all likelihood refuse to make payment for additional services. I have the right to continue in treatment at my own expense.

I understand that in situations wherein my health insurance is of the kind known as an "Indemnity plan," there may also be need for such disclosure regarding of my treatment. If I choose to submit claims to my insurance carrier under this type of plan, or if I ask my Psychologist to submit such claims on my behalf, these claims will contain the necessary identifying information, the dates of service (e.g., individual psychotherapy, psychological testing), a fee for that service and a diagnostic code.

Insurance Claim Submission

As a courtesy, we submit the insurance claims on your behalf, so that you receive reimbursement speedily. Claims are filed electronically, whenever possible.

Insurance Benefit Determination

It is your job to determine the benefits that your insurance carrier provides on your behalf.

Coordination of Benefits

You must check and inform us if you have more than one insurance policy. For example, you may have insurance coverage through your employer and your spouse. Sometimes, people ignore the insurance policy through their employer, and choose to gain coverage through their spouse's plan, because the financial coverage is better through the spouse's plan. **When you have TWO insurance policies, you cannot ignore your plan (through your employer) and choose to gain coverage through your spouse's policy**. The insurance companies are known to discover this (often years after therapy concluded), and they demand re-payment from us, if there was a primary policy in place. The correct procedure is to first file a claim through the primary insurance. Once that first claim is processed, we submit a claim to the secondary insurance plan.

If a secondary insurance plan conducts an audit and demands that my psychologist return all payments, I agree to reimburse my psychologist any fees the insurance takes back. In addition, I agree to reimburse my psychologist for the hours they spend trying to get the primary insurance to process the claims. The hourly cost for this service will be $50 per hour.

Changes in Insurance Coverage

It is your responsibility to notify your therapist of any changes to health insurance, immediately.

Reversal of Payment By Your Insurance Company

If your insurance company demands that we issue a refund to them for services they previously paid, you agree to reimburse your psychologist for these fees (example, your health insurance terminated. The company paid the fees, but then realized their error and demands a refund). **Patient Initial**_____ **Spouse Initial**_____

For Couples or Family Therapy

We have chosen to receive psychological and/or counseling services from the therapist whose name is checked above. Our choice is voluntary and we understand that we may terminate these services at any time. We are here to work on improving the emotional health of our family. Hence, we understand that our psychologist is committed to creating a safe environment where each of us feels free to share openly about our concerns and problems. We agree and understand that:

- It is not the job of the therapist to inform me of anything that my spouse might share with me.
- It is not the job of the therapist to take sides.
- In the event of any future legal actions, the therapist will not release any records.
- I understand that my therapist cannot take sides in any custody disputes.
- I understand that my therapist cannot make any child custody recommendations.
- I authorize my psychologist to speak with my spouse about relevant issues without my presence.

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We understand that there is no assurance that we will feel better or that our relationship will improve. Because psychotherapy is a cooperative effort between me and my psychologist, I will work with my therapist in a cooperative manner to resolve my difficulties.

Not applicable_____ **Patient Initial**_____ **Spouse Initial**_____

Payment

Payment is expected at the time services are rendered. We accept cash and checks. Please inform us if financial difficulties arise, so that we may work out plans that permit you to receive your therapy without excessive hardship. Occasionally, we will agree to have you pay your portion, while we wait for the insurance check. Many insurance companies do not honor assignment, which means they send the check to you, and not to us. In such cases, you agree that you will bring the insurance check to us promptly.

If you fail to honor the payment obligations that we agree upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require us to disclose otherwise confidential information. In most collection situations, the only information released is your name, nature of service provided, and the amount due. The costs of any legal actions will be added to your fees.

There is a $25 fee for bounced checks. Fees that are unpaid for 90 days may be turned over to a collection agency.

Patient Initial_____ **Spouse Initial**_____

Cancellation/Missed Session Policy

We realize that occasionally, illnesses or emergencies occur that are beyond your control. Hence, we allow one missed/late cancellation session per year. Otherwise, you must provide us with 48-hour cancellation notice, or you must pay as follows:

$25 for the second late cancellation or missed session.
$35 for the third late cancellation or missed session
$50 for any additional late cancellation or missed sessions

Please note that your insurance will not pay for any of these charges, and we may not bill for these missed sessions. .

Patient Initial_____ **Spouse Initial**_____

Policies Regarding Phone and Email

We do not charge for time spent on the phone or email for the discussion of any procedural matters such as appointment schedules and issues regarding insurance companies.

We do charge for phone time spent on therapeutic issues, at the pro-rated rates listed above. Also, time spent communicating to others on your behalf, either by phone or in writing, is also charged accordingly.

We do not use E-mails as communication method for therapeutic issues, since emails are an unsecure form of communication.

Patient Initial_____ **Spouse Initial**_____

Fees for Preparation of Disability/Court and all other Reports

I understand that there is a **minimum** charge of $25 for the preparation and submission of all reports that need to be faxed or mailed on my behalf to any disability company, employer or other external organization that requires the completion of forms on my behalf. Report preparation is charged on a pro-rated hourly rate of $100 per hour.

Patient Initial_____ **Spouse Initial**_____

The Health Insurance Portability and Accountability Act (HIPPAA)

The Health Insurance Portability and Accountability Act (HIPPAA) is a Federal Law that has been implemented to protect health services consumers. The provisions of this law, as privacy, confidentiality, content disclosure and reporting, are congruent with state laws already carried out by this practice. These policies will continue and are also required by HIPPA. The privacy of your health information is protected by appropriate procedures and policies, such as coding for identity concealment, as well as following official rules of consent and disclosure. For example, your records are available to you but disclosed to others only with your permission, unless disclosure is required by law. Also, there is protection of your confidential information by keeping records in secure places. Cooperation will be extended in the appropriate processing and transmission of forms, such as the provision of correct procedural and diagnostic codes. Essentially, as in the past, you will receive the protection of the rules of privacy, security, and transaction as currently mandated by HIPPA.

Please sign this form to indicate that you have received the information in sections I through VIII and that you understand your rights as a recipient of health services under HIPPA guidelines.

Signature of Patient #1 _____

Signature of Parent, if Patient is a minor_____

Signature of patient #2 _____
Date: _____