Emily E. Brislin, PsyD
Licensed Psychologist & Clinical Neuropsychologist
350 Sparta Ave., C-8
Sparta, NJ 07871
(973) 975-3641

CONSENT TO TREATMENT/PRACTICE POLICY & PROCEDURES
NOTICE OF PRIVACY PRACTICES/HIPPA

I have read and agree to the terms put forth in the attached consent to treatment. I understand that I am consenting to treatment with Emily Brislin, PsyD and agree to abide by all policies and procedures. These policies were explained to me during my initial consultation. I have also read and received a copy of the Notice of Privacy Practices, explaining my rights regarding my medical records under HIPAA (Health Information Portability and Accountability Act) and consent to this policy as written.

Signature of Client: _____

Witness/Therapist: _____

Date: _____

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Licensed Psychologist & Clinical Neuropsychologist
350 Sparta Ave., C-8
Sparta, NJ 07871
Phone: (973) 975-3641
Fax: (973) 426-3108

CONSENT TO TREATMENT

Independent Practitioners
Dr. Emily Brislin is an independent practitioner and does not have any affiliation with other professionals practicing at 350 Sparta Ave., C-8, Sparta, NJ 07871.
The facility and other practitioners practicing at said address are not liable for any claims related to services under the care of Dr. Brislin.

Initial Consultation:
This "initial consultation/assessment" is an opportunity for you to discuss any concern and/or problem from your point of view. As part of this assessment, historical and background information is gathered. Typically, diagnosis, prognosis, and treatment plan are discussed.

Appointments:
Sessions are by appointment only. Individual therapy is generally scheduled for 45 minutes. Because the appointment is reserved for you, it is necessary to charge for appointments which are not cancelled 24 hours in advance, unless in fact they are occasioned by circumstances which we would both define as an emergency. Failure to give 24-hour notice of cancellation means that another person in need is not able to use that appointment time. The charge for a no-show or late cancellation is **$25.00** which is required to be paid in order to reschedule your next therapy appointment. Insurance companies do not reimburse for late cancel or no showed appointment charges. A pattern of no-showed or cancelled appointments will lead to discharge.

Neuropsychological and Psychological Testing/Other Services:
At times, other psychotherapeutic services may be provided with your informed consent including assessment, diagnostic testing, or collaboration of treatment with another health care professional with or without you present. If administered a neuropsychological/psychological assessment or other psychological service, it will be billed to your insurance company according to standard CPT coding including but not limited to 96132, 96133, 96137, and 96138. Neuropsychological and psychological evaluations are billed for the administration of test, scoring, interpretation, report writing, and processing assessment with patient.

Treatment Benefits/Risks:
Psychotherapy may be extremely beneficial for many individuals while, at the same time, there are some risks involved. These risks may include experiencing intense and unwanted feelings. It is important to realize these feelings may be normal and are an important part of the therapeutic process. Other risks may include remembering past, unpleasant thoughts/beliefs, gaining an increased awareness of feelings, values and experiences, and possibly morbid thoughts.

Emergencies/Crisis:
In cases of an emergency/crisis, if I cannot be reached, please go to the nearest hospital emergency room or call 911, Sussex Co. crisis hotline at 973-383-0973, or Morris Co. crisis hotline at 973-540-0100.

Phone/Messages/Email:
I am often not immediately available by telephone as I do not accept calls during therapy sessions. Leaving a detailed voicemail is the preferred method of contact if you are unable to reach me in a non-urgent situation. I generally return all phone calls within 24-48 hours. Text messaging and e-mailing are discouraged, but may be permissible if mutually agreed upon and consisting only of information regarding appointment dates and times. I do not provide reminder calls for appointments due to time constraints.

Termination of Services:
Termination of services may be initiated at any time by either the client or the therapist. I have a right to feel comfortable with my client(s) as well as in all therapy sessions. If I feel you are conducting yourself in an abusive, hostile, uncooperative or inappropriate manner, I have the right to terminate all therapy. I request that if a decision is being made to terminate by you, that there be a minimum of a two week notice in order for a final termination/closure session to be scheduled to explore and discuss reason(s) for termination. Termination can occur when treatment goals are completed, multiple missed appointments, non-payment for services, client refuses treatment recommendations, or referral has been made to another therapist. If you are terminated by me or decide to leave treatment but wish to continue therapy with another provider, please contact your insurance company for a list of network providers to contact.

Records/Confidentiality:
All records are filed in an organized manner and kept in a locked room that allows for easy retrieval. These records are protected from public access. Records are maintained for seven years from the last date of service after which point, they are shredded and disposed of accordingly. Your confidentiality is protected by Federal and State Laws. Please read the enclosed form and discuss any questions with your therapist. Information will not be disclosed to anyone without your prior knowledge and informed consent.

Exceptions to Confidentiality:
Clear and imminent danger including suicidal/homicidal ideations or intent, child abuse, inappropriate sexual behaviors/incidents involving a child and/or sexual abuse; the client expressly gives permission when informed consent is given; client has waived the

right to privileged communication or has compromised through actions including involvement in a lawsuit, legal involvement, or discussing information in the presence of a third party; in a crisis situation or when hospitalization is immediately required; information released to your insurance plan in order for reimbursement; court ordered and duty to warn/protect; purposes of consultation/supervision from a licensed psychologist or psychotherapist.

NOTE: Despite all legal definitions of child abuse or sexual abuse, any information a client discloses that appears in nature to be child misconduct, inappropriate sexual behavior/incident involving a child, or past sexual/child abuse will be reported to the Child Abuse Hotline (1-877 NJ ABUSE) to investigate. My responsibility, ethically and legally, is that of a mandated reporter not an investigator.

Payment Policy/ Insurance/Payment:
All payment and copayment is due at the time of service. Dr. Emily Brislin is an in-network provider with Medicare, Cigna, United Healthcare and Blue Cross Blue Shield PPO plans. As the insurance policy holder, it is ultimately your responsibility to check your insurance benefits and to receive any authorization needed in order to participate in treatment. Regarding payment, 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 using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. [If such legal action is necessary, its costs will be included in the claim.] In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. No show/late cancellation costs must be paid prior to attending your next session. You will be held responsible for all costs and bank fees if a check is returned. You understand and consent to information to be disclosed to your insurance carrier for purposes of payment. (See HIPPA) I do not bill secondary insurances with the exception of those secondary to Medicare. If you prefer your information not be released to your insurance company for purpose of reimbursement, you will remain responsible for the fee for services.

Out-of-pocket Fee Schedule:

Initial Psychological Assessment:	$200.00
Psychological Testing:	$200.00/hr
Therapy Session:	$180.00
No-Show/Late Cancel (without 24 hour notice):	$25.00

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. The law also requires us to give you this Notice about your privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices as described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information we maintain, including health information we created or received before we made the changes. Prior to making any significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of this Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USE AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:

PAYMENT: We may use and disclose your health information to obtain payment for services rendered to you. We may also disclose your health information to another health care provider or entity that is subject to the Federal Privacy Rules for its payment activities.

YOUR AUTHORIZATION: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Without a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders such as voice messages, postcards, or letters.

SAFETY: If we determine that you are a danger to yourself or others, we will take necessary steps to protect those at risk, including informing the police and/or crisis intervention.

USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

- You seek treatment to avoid detection or apprehension or enable anyone to commit a crime
- Your therapist was appointed by the courts to evaluate you
- You file suit against your therapist for breach of duty or your therapist has filed suit against you
- You have filed suit against anyone and have claimed mental or emotional damage as part of your suit
- You are a minor and your therapist believes you are the victim of child abuse
- You are a person 65 years or older and your therapist believes you are the victim of physical abuse