Behavioral Care Center of New Jersey, LLC
205 Ridgedale Avenue, Suite 101
Florham Park, NJ 07932
Phone: (973) 660-0700

AUTHORIZATION FOR TREATMENT

I would like to start by extending a warm welcome. Making the decision to come to therapy is not always easy and I look forward to making this a helpful experience and to building a close collaborative relationship with you. In this document you will find important information about my services and about the business policies of this practice. Please read through this paper carefully and feel free to discuss with me any concerns that you may have or any information that is not clear. When you sign this document, it will represent an agreement between us.

Psychological Services:

I believe that each person is unique and requires an individualized and collaborative approach to his or her treatment. At the same time, I feel that it is very important to provide you with treatment that has been thoroughly researched to ensure that I am using treatments that have been shown to be helpful with other people with similar problems. Together we will identify your goals for therapy and outline a treatment plan that will allow us to work together towards achieving those goals.

Feel free to ask me further questions about the treatments that I utilize and how they may impact you. There are both benefits and risks involved in the therapeutic process. During therapy, you may be asked to discuss things that elicit uncomfortable feelings like sadness, guilt, anger, and helplessness. However, therapy can help to ameliorate feelings of distress, address maladaptive behaviors, and can also help foster better relationships both within the family and between peers.

The first few sessions will include an evaluation of your needs and goals. During this time we will also evaluate if I am the right therapist to work with you and to address your treatment goals. It is important that you feel comfortable working with me as the most effective therapies are those that take a collaborate approach to treatment. If at any time you have questions or concerns about my procedures, I would like for you to discuss them with me.

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Confidentiality:

Prior to beginning treatment, it is important for you to understand some rules about your confidentiality during the course of your treatment. Under HIPAA and the APA Ethics Code I am legally and ethically responsible for providing you with informed consent. Consultations, test results, and disclosures will be held in the strictest confidence subject to state law. Written authorizations will be required if you request that I share information with other persons or agencies.

There are certain situations in which, as a therapist, I am mandated by law to reveal information obtained during therapy to other persons or agencies without permission. These include the following:

- If I believe that a child or elderly person is being neglected or abused wither by physical or sexual means I am required to report the "reasonable suspicion" of such abuse. I have no authority to investigate the case. I must file a report with the state agency.
- If I believe that you are threatening serious harm to another person I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, and /or seeking hospitalization.
- If you threaten to harm to yourself in ways that may lead to suicide, or indicate that you are unable to control impulses which may lead to your suicide I am able to inform the individuals or agencies necessary to prevent the completion of such actions, including hospitalization.

Therapy is most effective when a trusting relationship exists between the therapist and the client. Privacy is especially important in securing and maintaining that trust.

Office Policies:

Psychotherapy appointments:

Appointments are generally made on a regular basis, and the 45 minutes are held for you. In the event that you are unable to keep your appointment due to a prearranged conflict I ask that you inform me as soon as possible. If you cancel within less than 24 hours of the appointment you will be charged the full

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fee for the missed sessions. My session fee is $____. Payment of fees will be expected at the time of service and there is a $25 fee for returned checks.

Additional Information:

You have the right to choose not to receive therapy from me at any time. If you choose this I will provide you with the names of other qualified professionals whose services you might prefer. You also have the right to ask any questions about or prevent the procedures used during therapy. In encourage that ask questions about my methods as they arise.

I am very pleased to welcome you as a client in my practice. Please feel free to discuss with me any problem that may arise regarding any of these policies. I look forward to a successful and beneficial relationship with you.

Patient name: _____ Patient Signature: _____

Clinician: _____ Date: _____

If the session has been canceled within less than 24 hours of the appointment or if I am carrying an overdue balance, I understand that the following credit card will be charged:

Credit Card type: master card visa

Credit Card number: _____

Expiration Date: _____

Signature: _____