A Freeman's Place Counseling

Brittany Freeman Jean-Louis, LPC
East Brunswick Professional Park
223 State Highway 18 Suite 102
East Brunswick, NJ 08816
732-997-7517

Hello and thank you for choosing A Freeman's Place Counseling. I look forward to our first meeting.
Your initial appointment will be one hour long. All subsequent appointments will be 45 minutes.

Parking is available in any of the spaces that are unmarked or designated. My office can be accessed from front entrance. Upon entering, please walk down the stairs, suite 102 will be straight ahead.

For your FIRST visit:

- Please contact your insurance company PRIOR to your initial visit to familiarize yourself with your benefits, co-pays and to obtain an authorization if necessary. Bring any authorization information your insurance gives you. (Note: Co-pays will be due after each session.)

- Please complete the Confidential Patient Information Form

- Please complete Mental/Medical History Form (pages 3 and 4)

- Please read and sign the Client's Rights, Patient Information/Informed Consent and the Confidentiality/Privacy Policy BRING ALL OF THESE COMPLETED DOCUMENTS WITH YOU TO YOUR FIRST APPOINTMENT, along with your insurance cards. If you experience difficulty completing the forms, please bring them with you to the first visit and I will assist you in completing them.

Please contact Brittany Freeman Jean-Louis (732) 997-7517 if you have additional questions.
If you need to cancel and/or reschedule your appointment, a 24 hour notice is required. Failure to give such notice will result in a $50.00 cancellation fee.

ALL RETURNED CHECKS WILL BE BILLED TO THE CLIENT AND NO FURTHER APPOINTMENTS WILL BE MADE UNTIL ALL FEES ARE PAID.

Again, thank you for choosing A Freeman's Place Counseling and I look forward to meeting your needs.

With much appreciation,
Brittany Freeman Jean-Louis, LPC

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CONFEDENTIAL PATIENT INFORMATION

Client Name: _____

Social Security #: _____-_____-_____ DOB: _____/_____/_____

Occupation:_____Employer:_____

Home Address: _____
(Street and Number) (City) (State) (Zip)

Home Phone:_____May I leave a message? □Yes □No
Cell/Work Phone:_____May I leave a message? □Yes □No

Where did you hear about us?: _____Internet, Please specify: _____

_____Insurance _____Friend/Family_____Other:_____

Emergency Contact: _____Phone: _____

Insurance Information

Name of Insured: _____DOB: _____

SS #: _____ Employer/School: _____

Address: _____
(Street and Number) (City) (State) (Zip)

Insurance Name: _____Phone:_____

ID#: _____Group #:_____

Goals for Therapy

Reason(s) for seeking therapy:_____

_____

What you would like to gain from therapy: _____

_____

Client/Parent/Guardian Signature: _____Date: _____

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MENTAL/MEDICAL HISTORY FORM
(PLEASE COMPLETE AND BRING WITH YOU TO THE FIRST SESSION)

CLIENT'S NAME:
_____

MENTAL HEALTH HISTORY:
Hospitalizations (name of hospital/dates/reason)
_____
_____
_____
_____

Therapies (name of therapist/dates/reason)
_____
_____
_____
_____
_____

MEDICAL HISTORY:
Hospitalizations (name of hospitals/dates/reason)
_____
_____
_____
_____

Medical Conditions (example: hypertension, cancer, etc .)
_____
_____
_____

Physical Symptoms (presently)
_____
_____
_____

MEDICATIONS: (please list all medications, vitamins and their dosage….use the back of this sheet if necessary)

Prescription Medications: **Medication** **Dosage**
_____
_____
_____
_____
_____
_____

Over the Counter Medications (example sinus meds, aspirins)

_____
_____
_____
_____

ALLERGIES:

_____
_____
_____

RELEVANT FAMILY HISTORY:
Family Medical History (include parents/siblings/grandparents)

_____
_____
_____
_____
_____
_____

Family Mental Health History (include parents/siblings/grandparents)

_____
_____
_____
_____
_____
_____

ADDICTION HISTORY:

_____
_____
_____
_____

ADDICTION TREATMENT HISTORY:
Inpatient/Residential Facility name of facility/dates in facility) Facility Date

_____
_____
_____
_____

Outpatient (name of sponsoring facility/therapist/dates)
Facility Date Therapist

_____
_____
_____
_____

Tobacco Use : Yes No If yes, how many a day?_____

Alcohol Use: Yes No If yes, amountconsumed:_____

Drug Use: Yes No If yes, type of drug/how often:_____

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STATEMENT OF CLIENT'S RIGHTS

You can be assured that A Freeman's Place Counseling wants to protect your rights. I strive to ensure that you receive all of your legal rights and that you are always treated with dignity and respect. Therefore, the purpose of the Client's Rights Statement is to inform you of your rights and obligations to A Freeman's Place Counseling as well as my obligations to you, in order to provide you with the most effective treatment possible according to your needs.

You have the right to;

1. Be treated with consideration and respect, regardless of race, age, sex, national origin, or legal status
2. Expect an appropriate referral to other places for treatment if we do no, or cannot, offer you the services that you need
3. Know that your records and private conversations are treated in a confidential manner and cannot be released without your consent, except under conditions included in the limitations of confidentiality
4. Obtain complete and current information concerning your treatment in terms which you can understand.
5. Refuse treatment, except when limited by court order or law and to be informed of the consequences of your refusal
6. Participate in the development of your treatment plan
7. Inform Creative Counseling Solutions if you are not in agreement with treatment being provided

YOUR RESPONSIBILITIES FOR CARE ARE;

1. To inform your clinician what you need
2. To be on time for your appointments; and to provide 24 hours advance notice if you cannot keep your appointment
3. To refrain from endangering others with your behavior

I understand the above statement of client's rights.

_____
Client/Parent/Guardian Name

_____ _____
Client/Parent/Guardian Signature Date

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PATIENT INFORMATION/INFORMED CONSENT

A. FEES AND BILLING

- Initial Appointment (45-60 Minutes): $175.00
- Individual Therapy Session (45 Minutes): $150.00
- Couples/Family Therapy Session (45 Minutes): $175.00

If at any point, there are changes in my insurance benefits (if applicable), I understand that I am responsible for all payments of services rendered. I understand that I am ultimately responsible for the full amount of my bill for services rendered, if my insurance denies/partially reimburses charges.

B. CANCELLATION FEE

Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for re-scheduling or cancelling an appointment. A fee of **$50.00** will be charged for a session missed without such notification.

C. INFORMED CONSENT

Information disclosed within sessions and the written records pertaining to those sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law. Information about you may be shared without your permission in the following situations;

If necessary to protect your safety or the safety of others.

a.) You threaten to harm yourself, or in my professional assessment, you are at risk of harming yourself. I am required by law to take action to ensure your safety, including contacting family members and arranging for hospitalization
b.) You threaten to harm someone else, or in my professional assessment, you are at risk of harming someone else. I am required to inform that individual and/or notify the appropriate authorities.
c.) You report knowledge of suspected child abuse and/or elderly abuse. I am required to report this to state authorities.

In the interest of securing coverage through your health insurance, I may be required to provide limited information as necessary to justify payment of your benefits. A Freeman's Place Counseling has no control over what insurance companies do with the information or who has access to this information. I authorize the release of any medical or other information necessary to process insurance claims. If applicable, I also request payment of government benefits either to myself or to the party who accepts assignment.

If you do not meet your financial obligations with A Freeman's Place Counseling as agreed, I have the right to collect unpaid accounts through a collection agency, or legal process. In this case, you are agreeing to waive confidentiality.

It is considered good professional practice to seek consultation in an effort to provide the best possible treatment. If this occurs, other professionals are also mandated by confidentiality. Your name or other identifying information remains completely anonymous.

I have read, understood, and agree to the policies and procedures described above and pertaining to; *Fees and Billing, Cancellation Fee, Informed Consent including limits of confidentiality*.

I have read this document thoroughly and, if necessary, have discussed and clarified my understanding of it with a representative of A Freeman's Place Counseling.

I authorize the release of any medical or other information necessary to process insurance claims for services rendered. I authorize the direct payment of medical benefits from my insurance company to A Freeman's Place Counseling/Brittany Freeman Jean-Louis for services rendered.

_____
Client/Parent/Guardian Name

_____
Client/Parent/Guardian Name

_____ _____
Client/Parent/Guardian Signature Date

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NOTICE OF CONFEDENTIALITY AND PRIVACY PRACTICES OF A FREEMAN'S PLACE COUNSELING

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization. We may also contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

- **Child Abuse or Neglect.** We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.
- **Judicial and Administrative Proceedings.** We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.
- **Deceased Patients.** We may disclose PHI regarding deceased patients as mandated by state law. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate.
- **Medical Emergencies.** We may use or disclose your protected health information in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.
- **Family Involvement in Care.** We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.
- **Health Oversight.** If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.
- **Law Enforcement.** We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.
- **Specialized Government Functions.** We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.
- **Public Health.** If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.
- **Public Safety.** We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- **Research.** PHI may only be disclosed after a special approval process.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI.

- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Brittany Freeman Jean-Louis, LPC or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

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NOTICE OF PRIVACY PRACTICES OF A FREEMAN'S PLACE COUNSELING

I have received a copy of and understand the HIPPA privacy rights information from A Freeman's Place Counseling.

_____ _____

Client Signature Date

A Freeman's Place Counseling

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The information on this page is very important because your signature at the bottom of this page acknowledges your understanding of and agreement to the contents of this page.

1. EMERGENCY PROCEDURES For psychiatric emergencies, please call 9-1-1 or go to the nearest emergency room. At your earliest convenience, please notify your clinician so follow-up can be arranged. Please contact your clinician's office to schedule an appointment for all non-emergency issues.

2. THERAPEUTIC EXPECTATIONS Your Clinician expects full and honest participation in treatment. Your Clinician will discuss your treatment and answer any questions you may have. Your Clinician respects your opinions, if a treatment is not working, please inform the clinician so that a different approach can be explored. Between sessions, at times assignments are often given as part of the treatment process; clinician expects full cooperation and participation.

3. FEES AND PAYMENTS (Please read this section carefully) Payments/Co-pays are due at the time of visit. Sorry, but there are no exceptions. (PLEASE CALL INSURANCE COMPANY TO FIND OUT HOW MUCH YOUR CO-PAY AMOUNT WILL BE, WHAT YOUR DEDUCTIBLE IS AND IF IT HAS BEEN SATISFIED) The clinician will not know. You are responsible for deductibles and co-pays. If your deductible is not satisfied at the time of the visit, you must pay the clinician the amount the insurance company would cover plus the co-pay. Please call your insurance company (see back of insurance card for telephone number) to familiarize yourself with your benefits, as there are times when a separate deducible for mental health claims are required. If you are a private pay client, all fees will be discussed and agreed upon before the service is rendered.

4. REPORTS (PLEASE READ THIS SECTION CAREFULLY) Please be advised that if letters and/reports are to be written on your behalf or forms to be filled out; an additional fee for these services will be charged. Unfortunately, these documents require additional time over and above the regular sessions.

5. CANCELLATION AND MISSED APPOINTMENTS (PLEASE READ THIS SECTION CAREFULLY) In non-emergent situations, you must give a 24-48 hours notice if you need to cancel your appointment. NON EMERGENT CANCELLATIONS with LESS THAN 24 HOURS NOTICE WILL BE BILLED A FEE OF $50.00 PER VIOLATION . Please note, insurance companies do not reimburse for missed appointments

6. COMPLAINTS If you have a complaint about your treatment, the clinician or any of our policies, please inform me immediately so I can address the concern. Please review our formal complaint procedure policy in confidentiality and privacy practices section.

7. CONSENT…VERY IMPORTANT… PLEASE READ I have been given a copy of A Freeman's Place Confidentiality and Privacy Policy . I have read the Confidentiality and Privacy Policy, I have had any questions answered to my satisfaction and I and I understand the Confidentiality and Privacy Policy. In addition, I accept, understand and agree to abide by the contents and terms of this agreement and consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time. I also understand that I am entitled to a copy of this document.

SIGNATURE OF CLIENT/PARENT/GUARDIAN :
_____

NAME OF CLIENT/PARENT/GUARDIAN (Please Print)
_____ DATE : _____