100 Campus Drive, Suite 101
Morganville, NJ 07751
732-617-6210
www.britefuturescounseling.com

Policy and Consent for Treatment

WELCOME to the mental health services of Brite Futures Counseling, LLC. We are pleased to have the opportunity to work with you and/or a loved one. We would like to take this opportunity to familiarize you with the policies and procedures at Brite Futures Counseling, LLC. **Please read the information carefully** and we encourage you to ask any questions regarding the material at any time of your session. Please be advised that any necessary signatures at the end, will demonstrate your acceptance to this agreement between all responsible parties and Brite Futures Counseling, LLC.

At Brite Futures Counseling, LLC we are dedicated to the personal, emotional, social, and/or behavioral concerns of all those we serve. We believe in offering support, compassion, and understanding to promote healthy skills and strategies. We attempt to provide a therapeutic approach where we are able to personalize therapies based on the needs and goals of those we work with. It is very important to recognize and understand that mental health therapy is a process which varies from person to person. Most importantly, the client(s) must be an active participant in the process, and we at Brite Futures Counseling, LLC cannot guarantee any desired results.

In any professional relationship, especially in the field of mental health, it is a necessary component for both the therapist and client(s) to feel comfortable working together for any and all treatment goal(s) decided during the initial phase into the process of therapy. We encourage you to evaluate your relationship with your therapist and address any concerns you may have during the session(s). We encourage our mental health professionals to look out for the best interest of the client(s) and by doing so; it may be in their professional judgment that referring you to another mental health practitioner either within Brite Futures Counseling, LLC or an outside establishment and/or individual, is in the best interest of the client(s).

Confidentiality:

The professional ethics and laws set forth for licensed mental health professionals in regards to confidentiality, prevent us from divulging any written and verbal records of information to anyone without your signed written permission. We also encourage you to read our current Notice of Privacy Practices Form which will be reviewed during the initial intake session and discussed in more detail within those pages. However, there are a few rare exceptions to confidentiality listed below.

1) Duty to warn and protect.

   A. When a client(s) discloses imminent intentions to harm another person or one's self, our licensed mental health professionals are required by the law to notify the intended victim, and/or the intended family, and/or report the information to the police and/or seek hospitalization for the client(s).

2) Abuse.

   A. When a child/minor reports that he or she is being abused and/or neglected, our licensed mental health professionals are required by law to report the information to the appropriate social service agency and/or the police. Furthermore, if the Child Protection and Permanency Agency (formally known as the Division of Youth and Family Services) request that our licensed mental health professionals release information to them, we are required by law to provide them with the requested information.

3) Legal.

   A. If presented with a court order signed by a judge, our licensed mental health professionals are required by law to release the records.

Insurance:

In any professional relationship, payment for services is an important matter. This is even more important in mental health, where clarity of relationships and responsibilities are a goal of treatment. Payments in the form of co-pay, out-of-pocket max, deductible amount, or payment in full are expected before each visit. If Brite Futures Counseling, LLC, is enrolled as an "in-network provider" within your insurance health plan, we will submit the claims to your insurance company on your behalf. We encourage you to verify with us as to which insurance companies we are a current participant with.

As a current provider for a number of insurance companies, Brite Futures Counseling, LLC has agreed on a contractual rate for specific services. In most instances, we have agreed to collect a set co-pay, out-of-pocket max, or deductible amount at the time of service. It would therefore be our responsibility to submit the claim after services rendered so that we can receive the rest of the fixed amount set by the insurance company. In some instances, your insurance plan may refuse payment for services rendered by Brite Futures Counseling, LLC at anytime. It would therefore be your responsibility to contact your insurance company to handle the matter further, and please be aware that you would be obligated to pay in full.

Our mental health sessions might be covered by other health plans if your coverage allows for "out-of-network coverage." This means that you would be responsible for paying the full fee for service, as listed below, before beginning a session. Brite Futures Counseling. LLC will provide you with a billing statement that contains the

appropriate diagnostic and procedural codes, fee for service rendered, as well as other necessary information required by most insurance carriers. You would be responsible to submit the billing statement to your insurance company for the appropriate reimbursement for the "out-of-network" mental health service(s) provided under your plan. Payment for reimbursement by your "out-of-network" provider in not guaranteed and Brite Futures Counseling, LLC is not responsible.

We encourage our entire prospective and current client base or parent/legal guardian to contact their insurance company to understand their outpatient mental health benefits and whether they have "in-network" or "out-of network" coverage. Here are some general you may want to ask:

- Whether a co-pay is required at the time services are rendered? If so, at what rate?
- Is there an annual deductible amount? If yes, has the amount been met?
- What does the insurance company consider a calendar year?
- Whether authorization is necessary for sessions?
- Amount of sessions allowed per calendar year?

We request that you advise us of any insurance changes immediately. Every effort will be made to assist you in collecting your claims, but all charges incurred are the responsibility of the patient or adult responsible party regardless of insurance coverage or reimbursement.

Fees:

Please be advised that the fees for service listed are for those clients who have an insurance plan in which Brite Futures Counseling, LCC is not an active participant or those who do not have current medical insurance. Also, be advised that some services listed below may not be reimbursed by your "in-network" insurance company; therefore fees listed for such services would be paid in full by the client/guardian. It will be the client/guardian's responsibility to be aware of any additional services listed above that are not deemed "Medically Necessary Covered Services" outside the client(s) mental health plan.

At Brite Futures Counseling, LLC, the mental health services and current service fees that are offered are:

Initial Diagnostic Interview at $120
Individual Psychotherapy (45 minutes) at $90
Individual Psychotherapy (30 minutes) at $60
Family Psychotherapy with or without Patient Present at $90
Group Psychotherapy at $50 (per person)
Written Report for Physicians, Agencies, Legal or Consultative Purposes at $120/per hour
Telephone Consultation (15-30 minutes) at $30
Telephone Consultation (31-45 minutes) at $60.

Brite Futures Counseling, LLC reserves the right to adjust or change the current fees on notice.

The office of Brite Futures Counseling, LLC expects our clients to be up-to-date on their balance. Please pay your bills promptly in order to avoid legal circumstances. If an account has not been paid within 30 days, we will notify you in writing and by telephone. If we do not receive payment within 60 days from date of service, it is our policy to turn your account over to a collection agency. It is agreed that if your account is referred to an outside agency or an attorney for collection, you (as the responsible party) will be accountable for an additional collection fee of twenty percent (20%) of the balance of your account or ($50.00), whichever is greater. Any account which has been sent to collections may be reported to the credit bureau. Also, note that any bank charges for returned checks will be your responsibility at a fee of $30.00 regardless of the amount of the check.

Minors/Couples:

As mentioned earlier, it is very important that the person(s) involved in therapy are an active participant in their own therapeutic process. This is why Brite Futures Counseling, LLC recognizes that in order to provide appropriate couples therapy, both partners must be present at each session, otherwise the session will need to be cancelled and a cancellation fee will be applied if 24 hour notice had not been applied accordingly as per our cancellation policy.

Brite Futures Counseling, LLC requires all individuals under the age of 18 years of age to have a parent/legal guardian sign a Consent for Mental Health Treatment Form before they can begin treatment. If the biological or legally adopted parents are currently separated or divorced, both parents would be required to sign our Consent for Mental Health Treatment Form before the child can be treated. If one of the parent's has full legal custody, a copy of the divorce agreement would need to be faxed to 732-617-6211 prior to beginning treatment for your child.

We at Brite Futures Counseling, LLC, believe children/minors deserve an environment that provides a sense of reflection while feeling safe, secure, and comfortable. We believe that an important component to this environment is to build a trusting relationship between the therapist and the client (child). Confidentiality between your child and the mental health professional is a part of the therapy process. We are legally obligated not to reveal information learned about your child to the parent(s) unless for the purpose to warn and protect the child or another person(s). We also believe that the parent(s)/legal guardian(s) are an integral part of the therapeutic process and we will certainly communicate with parents by providing general information about the therapeutic process.

Cancellation Policy:

Appointment times are set to accommodate our clients' schedules as often as possible. In order to receive the most success from therapy, it is in the client's best interest to keep their scheduled appointments on a regular basis. We encourage our clients to discuss any need to change an appointment. If you are unable to keep your

scheduled appointment, we require that you contact our office at 732-617-6210. Once an appointment has been scheduled, we have a cancellation policy which requires 24 hour notice

If you neglect to cancel your appointment with at least 24 hours advanced notice or miss an appointment entirely, there will be a late cancellation or "no show" fee of $50.00. By law, we are not permitted to submit a claim to any insurance company for late cancellations and missed appointments. At Brite Futures Counseling, LLC we recognize that unforeseen circumstances do transpire. We do permit our clients a **one-time** exception to our late cancellation or "no show" fee within a six month span during treatment. Please note that if a late cancellation or missed appointment should happen again after the "one-time exception," the client will then be charged a fee of $50.00. Any individuals who have neglected to adhere to our cancellation policy four or more times will immediately be required to sign our Mental Health Commitment Contract which will include stipulations to continue a professional relationship with Brite Futures Counseling, LLC.

Agreement:

I have read and understand the above information and agree that regardless of my insurance status, I am responsible for the payments of the balance collected for the person being serviced at Brite Futures Counseling, LLC at the time service is rendered. I also agree to consent to mental health treatment by Brite Futures Counseling, LLC of 100 Campus Drive, Suite 101 in Morganville, NJ 07751 for myself or my child or with my spouse/partner. As a representative of Brite Futures Counseling, LLC, the therapist signature and date below signifies an agreement between client(s) and Brite Futures Counseling, LLC. As a private run mental health facility, we reserve the right to review and determine in our professional discretion and judgment whether appropriate under certain circumstances to discontinue the relationship and potentially refer clients to professionals outside of Brite Futures Counseling, LLC at any time.

Print Client Name _____
(Self/Minor)

Client Signature _____ Date _____
(Self)

Print Client Name _____
(Spouse/Partner)

Client Signature _____ Date _____
(Spouse/Partner)

Print Parent/Legal Guardian Name _____

Parent/Legal Guardian Signature _____ Date _____

Therapist Signature _____ **Date** _____

100 Campus Drive, Suite 101
Morganville, NJ 07751
732-617-6210
www.britefuturescounseling.com

Registration Form (PLEASE PRINT NEATLY)

[Circle when appropriate]

CLIENT INFORMATION

Name: _____ **Today's Date:** _____
Last Name First Name Middle Initial

Home Address: _____

Home Town: _____ **State:** _____ **Zip:** _____

Gender: Male ___ Female ___ **Date of Birth:** _____ **Age:** _____

Occupation: _____ **Employer:** _____

Employer Address (include city/state): _____

Student: yes no Grade Level: _____

Name of School: _____

School Address (include town): _____

COUPLES THERAPY INFORMATION

(write **SAME** when appropriate)

Spouse/Partner Name: _____
Last Name First Name Middle Initial

Partner's Home Address: _____

Partner's Home Town: _____ **State:** _____ **Zip:** _____

Partner's Date of Birth: _____ **Age:** _____

Partner's Occupation: _____ **Employer:** _____

ONLY FOR CLIENTS UNDER Age 18

PARENT INFORMATION

(write **SAME** when appropriate)

Parents: Married Divorced Separated Deceased _____

Child Living with: Both Parents Mother Father Other_____

Mother's Name: _____
Last Name First Name Middle Initial

Mother's Home Address:_____

Mother's Home Town:_____ **State:**_____ **Zip:** _____

Mother's Date of Birth:_____ **Age:**_____

Mother's Occupation:_____ **Employer:**_____

Father's Name: _____
Last Name First Name Middle Initial

Father's Home Address:_____

Father's Home Town:_____ **State:**_____ **Zip:** _____

Father's Date of Birth:_____ **Age:**_____

Father's Occupation:_____ **Employer:**_____

PRIMARY INSURANCE INFORMATION

Person Responsible For Insurance _____
Last Name First Name Middle Initial

Relationship to Patient: Self Spouse Child Other **Date of Birth** _____

Employer_____ **Occupation** _____

Employer Address _____ **Phone #:** _____

Insurance Company _____ **ID#:** _____

Group #: _____ **Name of Plan:**_____

ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____ and
(Name of insurance company)
Hereby assign directly to Brite Futures Counseling, LLC all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Brite Futures Counseling, LLC to release all information necessary to the insurance company to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I also authorize the possible use of electronic billing to my insurance company by Brite Futures Counseling, LLC. I understand that all services provided outside of my mental health session, which are not covered by insurance, will be billed separately and I will be responsible in full, as per service fees.

Print Name _____

Client/Legal Guardian Signature _____ Date _____

Relationship to Client _____

BRITE FUTURES
COUNSELING, LLC

100 Campus Drive, Suite 101
Morganville, NJ 07751
www.britefuturescounseling.com

Client Communication Preferences

I would like to be contacted in reference to care by (please check and fill in *all that apply*):

Home Telephone #: _____

__ Okay to leave message with detailed information

__ Please leave a message with a call back number only

Work Phone #: _____

__ Okay to leave message with detailed information

__ Please leave a message with a call back number only

Cell Phone #: _____ OR _____

__ Okay to leave message with detailed information

__ Please leave a message with a call back number only

__ Confirmation text regarding upcoming appointment

Email Address(es): _____

__ Okay to leave message for office closings due only to **inclement weather** or closings due to **extenuating circumstances**

Print Name _____

Client Signature _____ Date _____
(or legally responsible party for minor)

100 Campus Drive, Suite 101
Morganville, NJ 07751
www.britefuturescounseling.com

Insurance Change Notification Policy

I am responsible to notify Brite Futures Counseling, LLC of any or all changes to my insurance coverage currently on file with Brite Futures Counseling, LLC whether this will result in a change to my copay, out-of-pocket max, deductible or a complete change to the insurance carrier. Regardless of change, I am required to notify Brite Futures Counseling, LLC at 732-617-6210 immediately. If I have advanced notice of this foreseeable change to my policy, I am asked to notify Brite Futures Counseling, LLC, but must notify them again once the change has taken effect.

Ultimately, I am aware that I am fully financially responsible for any services provided to myself or my family member(s) in the event that the insurance is no longer valid or if Brite Futures Counseling, LLC is not a participating provider with my new carrier.

Client Name(s)_____

Print Name _____

Client Signature _____ Date _____
(or legally responsible party for minor)

100 Campus Drive, Suite 101
Morganville, NJ 07751
732-617-6210
www.britefuturescounseling.com

Electronic Communication Guidelines and Policy

Email, texting, social media, video chatting, etc., have quickly become a fabric of our human interaction. Often many people feel more comfortable using these technologies as an alternative to communicating in-person or by telephone. Email and other electronic communication sent and received by Brite Futures Counseling, LLC is not in any way intended to be used for any mental health treatment, advice, suggestions, counseling and/or related to the client's therapy sessions over the Internet. The aforementioned services must be conducted in a therapeutic session or by telephone. Electronic communication such as email is not intended for a crisis situation. If you or the client is experiencing a true life clinical emergency, please consider the following options: (1) dial 911; (2) go to your nearest emergency room; (3) contact the local crisis line at 732-923-6999; (4) or contact Mobile Response at 877-652-7624 (for children). Please contact our office at 732-617-6210 for an appointment or get into contact with your mental health therapist.

Please be advised that electronic communication is not completely secure and confidential although many measures have been put into place by Brite Futures Counseling, LLC. Anytime information is transmitted electronically using the Internet and other services or networks it is compromised due to the nature of how the information is sent and delivered to technology devices, computers, etc. Furthermore, any information you send and receive by Brite Futures Counseling, LLC becomes a part of the client's legal record.

Email and other electronic communication are intended for basic information about Brite Futures Counseling, LLC and arranging or modifying appointments. Please keep all requests to no more than one short paragraph. Be advised that email is checked during business hours only and is not checked on weekends or holidays. We will respond to any requests within two business days of receipt.

By signing below, you and/or the client understand the disclosures listed above regarding communication with Brite Futures Counseling, LLC and its employees using any form of electronic communication such as email and text messaging. Client and/or I acknowledge and understand that if an email is sent and I request a response via electronic communication, that the client and/or I are willing to accept the above-stated risks. The client and/or I agree that such electronic communication such as email will not be used for a crisis/emergency, mental health treatment, advice, suggestions, counseling and/or related to the client's therapy sessions.

Print Client Name _____
(Self/Minor)

Client Signature _____ Date _____
(Self)

Print Client Name _____
(Spouse/Partner)

Client Signature _____ Date _____
(Spouse/Partner)

Print Parent/Legal Guardian Name _____

Parent/Legal Guardian Signature _____ Date _____

100 Campus Drive, Suite 101
Morganville, NJ 07751
732-617-6210
www.britefuturescounseling.com

Notice of Privacy Practices

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.

Client health records contain personal information about the client and their health. This information, which may identify the client and relates to their 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 at Brite Futures Counseling, LLC may use and disclose the client PHI in accordance with applicable law. It also describes client rights regarding how they may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide clients 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 the 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 client's with a copy of the revised Notice of Privacy Practices by sending a copy to them in the mail upon request, or providing one to the client at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT THE CLIENT:

For Treatment. The client's PHI may be used and disclosed by us for the purpose of providing, coordinating, or managing the client's 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.

For Payment. Brite Futures Counseling, LLC may use or disclose PHI so that we can receive payment for the treatment services provided to the client. 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, the client's PHI in order to support our business activities including, but not limited to, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, and conducting or arranging for other business activities. For example, we may share the client's 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 the PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of the client's 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 Brite Futures Counseling, LLC compliance with requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect	**Judicial and Administrative Proceedings**
Emergencies	**Law Enforcement**
National Security	**Public Safety (Duty to Warn)**

Without Authorization. Applicable law and ethical standards permit us to disclose information about the client without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the marriage and family licensing board or the health department)
- Required by Court Order
- 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.

Verbal Permission. We may use or disclose client information to family members that are directly involved in the 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

You have the following rights regarding client personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to us, Brite Futures Counseling, LLC, at 100 Campus Drive, Suite 101, Morganville, NJ 07751.

- **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 may be used to make decisions about client 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 the client. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI that we have about the client is incorrect or incomplete, you may ask us to amend the information, although Brite Futures Counseling, LLC is not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain amount of the disclosures that we make to client 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 the PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that Brite Futures Counseling, LLC communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this Notice.
- **Electronic Transactions Standards.**

COMPLAINTS

If you believe that the client's privacy rights have been violated and wish to file a complaint with our office, you have the right to file a complaint in writing to us at: Brite Futures Counseling, LLC, 100 Campus Drive, Suite 101, Morganville, NJ 07751. You may also send a written complaint to the Secretary of Health and Human Services at: 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. You have specific rights under the privacy rule. **We will not retaliate against the client for exercising your right to file a complaint.**

I acknowledge that I have read and understand the above information:

Print Name_____

Client Signature_____
(or legally responsible party for minor)

The effective date of this Notice was received _____
(do **not** fill in—for office use)

BRITE FUTURES
COUNSELING, LLC

100 Campus Drive, Suite 101
Morganville, NJ 07751
732-617-6210
www.britefuturescounseling.com

Consent for Mental Health Treatment of Minors

I, _____, do hereby authorize that my child,
(parent/legal guardian name)

_____, may receive mental health treatment
(child's name)

provided under the establishment of Brite Futures Counseling, LLC. I am aware that all custodial parents and legal guardians must give consent before treatment begins. If the biological or legally adopted parents are currently separated or divorced, both parents would be required to sign a Consent for Mental Health Treatment Form before the child can be treated. If one of the parent's has full legal custody, a copy of the divorce agreement would need to be faxed to 732-617-6211 prior to beginning treatment for your child.

Print Name _____

Parent/Legal Guardian Signature _____

Date _____