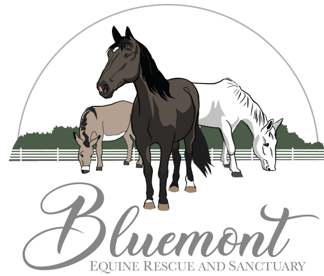

LIABILITY RELEASE AND HOLD HARMLESS AGREEMENT

****
Under New Jersey Law, an equine professional is not liable for an injury or death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to Section NJSA 5:15-1 to 5:15-1 12

****

NAMES: ____
NAMES: ____
ADDRESS: ____
CITY/STATE: ____ **ZIP**: _____________
CONTACT PHONE: _______________________

ACKNOWLEDGEMENT OF RISK

I / We, ________________________ ________________________ as well as all Minor Children in Guardianship, acknowledge that I have read the above statements and definitions, and hereby indemnify and hold harmless, Bluemont Sanctuary & Operation Hope. As well as its employees – volunteers and owners from any liability. This Includes but is not limited to and accident, injury, theft, or damages to myself, my representatives, my family, all equipment and property, and all animals under my jurisdiction. I have reviewed the safety tips and rules and will adhere to them strictly. This agreement shall continue for each and every visit to Bluemont Sanctuary's property.

The terms of this release form shall be construed as the entire agreement and may not be altered, amended, or modified except in writing and signed by both parties. The terms of this release shall be governed by the laws of the State of New Jersey
If under 21, the parent or guardian must read and sign the above, indicting his/her acceptance.

Date: _________ Name:____________________ **Signature** : __________________________

Date: _________ Name:____________________ **Signature** : __________________________

Date: _________ Name:____________________ **Signature** : __________________________

Date: _________ Name:____________________ **Signature** : __________________________

List of Minor Children: (Please Include Names & Age)

Credit Card Form:

Please note we keep a credit card on file for cancellations with less than 24 hours' notice, no shows, or for default in payment.

Credit Card Type:______________________________Credit Card Number: __________________________

Credit Card Code:_____________________________Exp. Date: _________
____

Credit Card Name as it appears: ________________________
____

Client/Guardian Name:
Signature:

Date:

Operation HOPE
www.operationhopenj.com
732-497-8078

Credit Card Payment Authorization

PHONE/VIDEO SESSIONS: When participating in video or phone sessions, I authorize my therapist to charge my credit/debit card at the time of the session or afterwards.

MISSED SESSIONS: I understand that when I schedule an appointment, whether in- person or by video or phone, that time is held for me. I also understand that insurance or EAP plans typically will not pay for missed sessions. Therefore, I understand if I cancel or reschedule a session without 24 hours' notice or if I do not show for the appointment, I authorize my therapist to charge my credit or debit card for the missed session. If using insurance, the missed session fee will be the full session fee (not just my insurance copayment).

HEALTH SAVINGS ACCOUNTS (HSA) CARDS: If I have an HSA credit card, I authorize my therapist to charge the card for services at the time of the service or afterwards. I understand that missed sessions cannot be billed to HSA credit cards, nor can I bill sessions in advance on HSA cards.

OTHER CHARGES: I understand other charges that may be billed to my credit/debit card are bank fees for bounced checks or any balances not paid within 30 days.

OTHER PAYMENT OPTIONS: If I prefer not to use my credit card, I understand I may pay in advance for sessions by sending a check. However, I understand that a credit card may be charged by my therapist to cover missed sessions, bounced checks, and unpaid balances.

CREDIT CARD INFORMATION: In order to comply with Payment Card Industry Data Security Standards (PCI DSS), which are designed to prevent data theft and fraud, I understand that my credit/debit card information will not be stored in my medical record. I understand that I will give my credit card information verbally to my therapist and it will be immediately entered into a credit card processing portal which performs data encryption for added security.

I verify that the credit card information I provide is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest/additional costs incurred if denied.

____

Signature　　　　　　　　Printed Name　　　　　　　　Date

EQUINE ACTIVITY LIABILITY RELEASE, WAIVER OF RIGHT TO SUE AND ASSUMPTION OF ALL RISKS

This Equine Activity Liability Release, Waiver of Right to Sue and Assumption of All Risks Agreement ("this Agreement") is hereby given by the undersigned (i) to True Connections Stable, LLC and owners Paula and David Sagui and Jessica Sagui and 211 Bennet Realty, LLC and agents and provides as follows:

In consideration for the opportunities provided by True Connections Stable, LLC to the undersigned (including any minor in whose behalf the undersigned signs this Agreement) (the “participant”) by the use of stable’s or other’s horse(s) for the enjoyment of equine activities as a participant, the participant, including any minor participant for whom he signs this Agreement, hereby agrees as follows:

1. This Agreement is given in part under the **New Jersey Equine Activity Statute** (**NJ ST 5:15-1, et seq.)** as it may now provide or be hereafter amended (the "Statute"). All terms defined by the Stature shall have the same meaning herein, and the Stature is hereby incorporated in this Agreement. This Agreement shall be so construed as to provide to the Stable, owners, facility and agents the fullest protection of a release, waiver of right to sue and assumption of all risks that is afforded by the Statute, by other applicable statutes and by general law.
2. The participant hereby acknowledges that he has full and complete notice and understanding of the Statute and of all the risks inherent in equine activities which may cause, contribute to or result in the death or personal injury of the participant or damage to the participant's property (the "Risks"). These risks include, but are not limited to: (I) the propensity of equines to behave in ways that may result in injury, harm, or death to persons on or around them; (ii) the unpredictability of an equine's reaction to such things as sounds, sudden movement, and unfamiliar objects, persons, or other animals; (iii) certain hazards such as surface and subsurface conditions; (iv) collisions with other animals or objects; (v) the potential of a participant acting in a negligent manner that may contribute to injury to the participant or others, such as failing to maintain control over the equine or not acting within the participant’s ability; (vi) the propensity of an equine to behave in dangerous ways or to trip and/or fall; (vii) the inability of anyone whomsoever to predict or foresee an equine's reaction to excitement, weather conditions, sound, movements, objects, vehicles, persons, animals, reptiles, birds or insects, and the effects of such reactions; (viii) the hazards of surface or subsurface conditions, including but not limited to objects or conditions on, under or protruding from the surface both latent and patent; (ix) the hazards which rocks, cliffs, hills, fences, trees, stumps, logs, bridges, ditches, bodies of water, debris and obstacles, and any equine activity in connection therewith, may foreseeably or unforeseeably present; (x) the dangers and risks of tack or harness slipping or breaking for whatever reason; (xi) the dangers and risks of becoming entangled in tack, harness, or vehicles used in an equine activity; (xii) the risks of falling from or otherwise becoming unstable on an equine or a vehicle used in an equine activity for any reason whatsoever or for no identifiable reason; (xiii) the dangers of being struck by an equine, or by rider; (xiv) any negligent act or omission by the horse owners, family members or agents which causes or results in the death or personal injury of the participant or damage to the participant's property; and (xv) all other risks associated with horseback riding, [handling horses, and related activities.
3. The participant hereby RELEASES and WAIVES all rights which he may have or hereafter have against the Stable, facility and agents for injury, loss, damage or death which is in any way resulting from the intrinsic dangers of equine activities and/or associated with the Risks enumerated in Paragraph 2 above; he does hereby WAIVE his right to sue or to bring any action against the horse owners, and agents in connection therewith; he agrees to INDEMNIFY and DEFEND the horse owners, and agents from and to HOLD the Stable, owners, facility and agents HARMLESS against any such suit or action including reimbursement of legal fees associated with the defense of any claim; and he hereby expressly ASSUMES ALL RISKS AND DANGERS of injury, loss, damage or death which are in any way resulting from the intrinsic dangers of equine activities and/or associated with the Risks enumerated in paragraph 2 above, including an act or omission that constitutes negligence for the safety of the participant by the horse owners or any other person .
4. The participant agrees that it is their own responsibility (i) to judge their ability to ride a specific animal or participate in an activity, (ii) to wear appropriate clothing, footwear and safety gear, including but not limited to protective equestrian helmet, (iii) inspect all tack prior to use and (iv) to observe appropriate safety precautions when riding or handling the horse(s). The participant also agrees to not act in a manner that may endanger himself, the horse(s) or others.
5. The participant hereby RELEASES and WAIVES all rights which he may have or hereafter have against the Stable, facility and agents for injury, loss, damage or death which is in any way resulting from riding in or proximity to (for any purpose, destination or location) any motor vehicle or farm vehicle owned or operated by a True Connections Stable owner or employee.
6. The participant hereby authorizes and consents to any emergency medical care which may at the time appear reasonably appropriate under the circumstances as a result of injury or sickness caused by or incurred in the course of an equine activity.

7. This Agreement shall remain valid and in full force and effect from and after the date opposite the signature of the Participant until expressly revoked by the Participant in a written notice personally delivered to the stable owners. 8. To the extent possible, this Agreement shall be construed in such manner as will render it, and each provision of it, fully enforceable; but if any provision of this Agreement shall be unenforceable, such provision (or so much thereof as is unenforceable) shall be deleted and the remainder of this Agreement shall continue in full force and effect. 9. If this Agreement is executed by the undersigned for and on behalf of a minor participant named below, the undersigned hereby

warrants and represents that he is in fact the legal parent or guardian of such minor, with full rights of custody and control; that this Agreement is given on behalf of and is intended to be binding upon said minor participant, his heirs, personal representatives, successors and assigns; and the undersigned further agrees that this Agreement shall also be as fully binding on the undersigned as if it were entered into solely on his own behalf.

10. This Agreement shall be binding upon the heirs, personal representatives, successors and assigns of the participant and the undersigned.

WARNING: UNDER NEW JERSEY LAW, AN EQUESTRIAN AREA OPERATOR IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ANIMAL ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ANIMAL ACTIVITIES, PURSUANT TO P.L., CHAPTER 287

I HAVE FULLY READ AND FULLY UNDERSTAND THE FOREGOING EQUINE LIABILITY RELEASE, WAIVER OF RIGHT TO SUE AND ASSUMPTION OF ALL RISKS. I HAVE CONSULTED AND RELIED UPON MY OWN ADVISORS ON ALL QUESTIONS IN CONNECTION THEREWITH, AND I HAVE NOT RELIED UPON THE STABLE OWNERS, OR ANY AGENT FOR ANY ADVICE OR EXPLANATION IN CONNECTION THEREWITH.

Print Name:

____

_ *(parent or legal guardian if signing for minor participant, otherwise adult participant)*

Date:____________________ ______________________________________ Adult or Parent's Signature

FOR MINORS UNDER 18 YEARS OF AGE:

Print Name of Minor Participant for Whom Signing:

____ Minor's Birthdate: ____________________

Date: _____________________ ____
Minor's Signature

Contact Information

Home Phone: ______________________________ Cell Phone: ___________________________________

Street: ____

City / Zip: ____

Email: ____

Emergency Contact: _________________________________ Phone Number:

____

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 IT CAREFULLY.

I am required by law to maintain the privacy and security of your protected health information ("PHI") and to provide you with this Notice of Privacy Practices ("Notice"). I must abide by the terms of this Notice, and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

Except for the specific purposes set forth below, I will use and disclose your PHI only with your written authorization ("Authorization"). It is your right to revoke such Authorization at any time by giving me written notice of your revocation.

Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Written Consent. I can use and disclose your PHI without your Authorization for the following reasons:

1. **For your treatment**. I can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a physician or a psychiatrist, I can disclose your PHI to him or her to help coordinate your care, although my preference is for you to give me an Authorization to do so.
2. **To obtain payment for your treatment**. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company to get paid for the health care services that I have provided to you, although my preference is for you to give me an Authorization to do so.
3. **For health care operations**. I can use and disclose your PHI for purposes of conducting health care operations pertaining to my practice, including contacting you when necessary. For example, I may need to disclose your PHI to my attorney to obtain advice about complying with applicable laws.

Certain Uses and Disclosures Require Your Authorization.

1. **Psychotherapy Notes**. I do not keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501; rather, I keep a record of your treatment and you may request a copy of such record at any time, or you may request that I prepare a summary of your treatment. There may be reasonable, cost-based fees involved with copying the record or preparing the summary.
2. **Marketing Purposes**. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. **Sale of PHI**. As a psychotherapist, I will not sell your PHI in the regular course of my business.

Certain Uses and Disclosures Do Not Require Your Authorization. Subject to certain limitations mandated by law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including**,** ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

(continued on back)

Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. **Disclosures to family, friends, or others**. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

YOUR RIGHTS YOUR REGARDING YOUR PHI

You have the following rights with respect to your PHI:

1. **The Right to Request Limits on Uses and Disclosures of Your PHI**. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. **The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full.** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. **The Right to Choose How I Send PHI to You**. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. **The Right to See and Get Copies of Your PHI**. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you.
   I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost-based fee for doing so.
5. **The Right to Get a List of the Disclosures I Have Made**.
   You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.
6. **The Right to Correct or Update Your PHI**. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. **The Right to Get a Paper or Electronic Copy of this Notice**. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think I may have violated your privacy rights, you may file a complaint with me, as the Privacy Officer for my practice, and my address and telephone number are: ____.

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:

1. Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;
2. Calling 1-877-696-6775; or,
3. Visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

I will not retaliate against you if you file a complaint about my privacy practices.

EFFECTIVE DATE OF THIS NOTICE
This notice went into effect on ________________________.

Operation HOPE, LLC

Informed Consent for Behavioral Health Therapy Services

SERVICE AGREEMENT

Welcome to Operation HOPE, LLC. This document contains important information about our professional services and business policies. Although these documents are long and sometimes detailed, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future. Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. Operation HOPE, LLC. have/has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

I. SERVICES Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, (sadness, guilt, anxiety, anger, frustration, loneliness and helplessness), because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. There are, however, no guarantees about what will happen. Psychotherapy

requires a very active effort on your part. Operation HOPE, LLC. offers a treatment modality called Equine Assisted Psychotherapy which is an experiential form of psychotherapy where horses are involved in the sessions. “Experiential” means that you will be involved in hands-on experiences with the horses designed to reflect things going on in your life. The process is not always about interacting with the treatment team, although that will happen at times. It is about providing you the opportunity to experience, explore, problem-solve, discover, be creative, gain insight and experience practical applications of what you are learning in the moment. The process is about “doing” along with the “talking.” Why horses? There are several reasons we choose to use horses in this work, but primarily it is due to their nature as a social and prey animal. As a result of this nature, they have an extraordinary ability to read our nonverbal communication – picking up on messages we are sending which we are not always conscious we are doing. With this, they start responding to us in familiar ways reminding us of other people and things in our life. It is through this they become metaphors (symbols) providing us the opportunity to work on ourselves in relation to those aspects of our lives. Horses do not know our past, education, gender, race or other labels we may apply to ourselves and each other. They are in the moment and can be a part of this relationship without the biases we humans put on each other. This provides even more value in the insight they can provide us about ourselves. There are some risks in being around horses due to their size and nature of being an animal. This is covered in the Liability Release Form we have provided for your review and signature and which we have covered verbally with you. It is important you understand the risks and benefits and ask any questions you may have about that in making your decision to be involved in these services. Operation HOPE, LLC. follows the EAGALA Model of Equine Assisted Psychotherapy. This means: 1.Sessions are conducted by a facilitating team (treatment

team) of a Licensed Mental Health Professional (MH) and a qualified Equine Specialist (ES) in all your sessions. These professionals are EAGALA Certified which means completion of specialized training in this model, requirements of ongoing continuing education and adherence to high standards of professionalism and practice. While both members of the team are involved in your therapy process, the role of the ES is to oversee physical safety needs and provide observations on the behaviors of the horses. The MH is there to oversee the psychotherapy process and help you make the parallels of the horse observations to your therapy goals and life. Please see our brochure to read more about our biographies. 2.All sessions are on the ground – there is no riding of horses involved in the treatment process. This is psychotherapy and even though you may learn a thing or two about horses, it is not the intent or focus to learn about horses or how to ride them. We are here to address your therapy goals and we commit to utilizing the methods we have found to best support that focus. 3.The process is solution-oriented – meaning we believe you have the best solutions for yourself when provided the opportunity to discover them. We are here to provide the space and guidance through exploring what is happening in the process. You are an individual, and every life situation you are involved in will have its own unique solutions which fit best for you – we are here along with the horses to help you find them. 4.This process also incorporates "Best Practice" or "Evidence Based" interventions as determined by the Mental Health profession. 5.EAGALA is an international, nonprofit professional association for Equine Assisted Psychotherapy and has standards and a code of ethics which we follow and have accountability to as EAGALA Certified professionals. You may review a copy of the Code of Ethics as well as go to www.eagala.org for more information. You can read more about why horses and EAGALA Model Equine Assisted Psychotherapy at www.eagala.org and feel free to ask questions at any time. The first 2 sessions will involve

assessing your needs and working with you to create a treatment plan to outline your therapy goals and objectives and address any questions regarding diagnosis, goals and estimated length of treatment. We will periodically review this plan with you to discuss progress or changes in the therapy goals. If you have questions about our procedures, please discuss them with us whenever they arise.

II. APPOINTMENTS Appointments will ordinarily be 60 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. If you need to cancel or reschedule a session, we ask that you provide us with 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hours notice, our policy is to collect 50% of the session fee (unless we both agree that you were unable to attend due to circumstances beyond your control). If it is possible, we will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

III. PROFESSIONAL FEES The standard fee for sessions is $250.00. You are responsible for paying at the time of your session (start of session) unless prior arrangements have been made. [Payment may be made by check or cash; we are not able to process credit card charges as payment.] Any checks returned to our office are subject to an additional fee of up to $25.00 to cover the bank fee that we incur. If you refuse to pay your debt, we reserve the right to use an attorney or collection agency to secure payment. We have the right to terminate care for non-payment with appropriate planning for your treatment needs. In addition to appointments, it is our practice to charge this amount on a prorated basis (we will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes,

attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of us. If you anticipate becoming involved in a court case, we recommend that you discuss this with us fully before you waive your right to confidentiality. If your case requires our participation, you will be expected to pay for the professional time required even if another party compels us to testify. In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. You are responsible for knowing your coverage. If you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees – you are responsible for this. We do not bill insurance companies directly, nor do we participate as in-network providers. We will supply you with a receipt of payment for psychotherapy services that you can submit to your insurance for reimbursement. Please note that they may not reimburse all the fees per your coverage agreements, and not all insurance companies reimburse for out-of-network providers so make sure you check with your insurance company in advance of beginning treatment.

IV. PROFESSIONAL RECORDS We are required to keep appropriate records of the therapy services we provide. Your records are maintained in a secure location per professional standards. We keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records we receive from other providers, copies of records we send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, we

recommend that you initially review them with us, or have them forwarded to another mental health professional to discuss the contents. If we refuse your request for access to your records, you have a right to have our decision reviewed by another mental health professional, which we will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

V. CONFIDENTIALITY All sessions and their content, as well as your records, will be kept strictly confidential. To the extent possible, you will be informed before confidential information is disclosed, and in that event only the essential information required by law or to collect payment will be revealed. There are legal limits to this confidentiality creating circumstances in which we may disclose mental health records without consent or authorization which include: 1) If we feel you are a danger to yourself or others, 2) If we suspect a child or elderly or incapacitated person is abused or neglected, 3) Disclosure is required by the court. Information about your privacy rights is described in a separate document entitled HIPAA Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

VI. CONTACTING US We are often not immediately available by telephone. We do not answer our phone when in session with clients or otherwise unavailable. At these times, you may leave a message on our confidential voice mail and your call will be returned as soon as possible. If, for any number of unforeseen reasons, you do not hear from us or we are unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, please go to your local hospital emergency room or call 911 and ask to speak to the mental health worker on call.

VII. EMERGENCY POLICY In the event of an emergency please consider the following: We will call 911.

VIII. OTHER RIGHTS If you are unhappy with what is happening in therapy, we hope you will talk with us so that we can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that we refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about our specific training and experience. You have the right to expect that we will not have social or sexual relationships with clients or with former clients. Your signature below indicates that you have read and understand this Agreement and agree to their terms.

____

Signature of Patient or Personal Representative

____

Printed Name of Patient or Personal Representative

Date

____

Date:_________________________

New Client Registration

YOUR NAME:____ Social Security Number: ___________-__________-____________

Date of birth: _______/________/___________ Relationship status: ___________________Height: ____'_____" Weight____________

Address:____ City:______________________ Zip:__________________

Home Phone: (__________)__________________________________ Work: (__________)_______________________________

Cell Phone: (__________)__________________________________ Other: (__________)_______________________________

E-mail :____

Occupation:________________________________ If employed, employer name:____

If in relationship, how long? ______________ Previously married? ________If so, how often, and how long?____________________

Insurance Plan:________________________________ **Full Name of primary insured**:_______________________________________

If primary insured is not you, give their date of birth: _____/______/_______ **and their employer**:______________________________

Name of Insured: Relationship to you:

Date of Birth of Insured: Insurance Name/Type:

Insurance Address:

Insurance Phone:

Insurance ID Number: Group ID Number:

Emergency Contact____________________________ Phone:(______)________________ Relationship:_______________

Primary Doctor::____ Phone: (_______)_________________________

Doctor's address:____ City:____________________________________

Psychiatrist (if any): ____ Phone: (_______)______________________

Psychiatrist's address:____ City:______________________________________

Health Issues/Allergies: ____

Medications and Over-the-Counter Drugs taken regularly (include dosages and why you take them):______________________________

____

Who referred you to this practice? ____________________________________ **Did you view our website before coming?**_________

Monmouth County, NJ

Phone: ___________ Fax: _______________ Email:________________

CONSENT FOR RELEASE AND EXCHANGE OF INFORMATION

Clients Name: ____

I hereby authorize the following party to release to and/or exchange information with _____________________ (therapist name):

Name: ____

Address: ____

____

Phone: _________________________ Fax: _________________________

The purpose of this release is for:

______ Continuity of care
______ Coordination of care with another treating healthcare provider
______ Insurance plan or third-party-payer review of records for quality and level of care and/or justification of charges, and as needed to authorize more sessions or to process claims, or to fulfill administrative review by plan
_____Other: ____

The information released will be limited to:

______ Attendance
______ Summary of pertinent psychiatric and psychosocial history
______ Treatment summary
______ Complete mental health assessment and treatment records
______ Any information deemed necessary to coordinate care
______ Other____

The requesting party certifies that information will not be used for any purpose other than its intended use, and will not be re-released to another

party. The client understands that s/he has a right to a copy of this form. This consent is subject to revocation at any time except to the extent that action has been already taken in reliance thereon. If not revoked earlier, this consent expires three years from the date signed.

____ ______________
Signature Date

____ ______________
Second Party Signature Date

TREATMENT AGREEMENT

CLIENT NAME:____

Please initial in each box on the left after reading the text to the right:

INITIAL BELOW	
	FEES: The fee per 50-minute session is $__250___. This is due at the time of our session in cash or check or credit card, *unless I am billing your insurance, in which case you must pay your copayment and/or deductible at the session*.
	CANCELLATION: Sessions are by appointment only. While I hate charging for missed sessions, I do reserve that time for you. Therefore, you will be charged $___175_____ (not just a copayment) for missed sessions or for those cancelled without 24-hour notice, except in medical emergency. Insurance will not pay for missed sessions. Since your time is also valuable, if I forget a session, you get one session free.
	INSURANCE: If I am a provider with your plan: I will submit claims for you, but at our session you must pay any copayment or coinsurance or any portion not covered by your plan. There may be a deductible (an amount you will need to pay out of pocket) before your plan begins coverings sessions. If insurance does not pay as expected, you remain responsible for the balance. You have the right to waive using insurance coverage, if desired. **If I am NOT a provider for your plan:** You will pay me in full at the session. I can give you an invoice if you wish to seek reimbursement from your plan. Many plans do not cover sessions with a provider who is not in their network.
	SECONDARY INSURANCE: It is your responsibility to tell me about all possible insurance plans that might cover my services (ex. if you have Medicare in addition to a secondary policy, or coverage through your work and a family member's work). If you do not, you may be responsible in full if claims are denied.
	DIAGNOSIS: Please be aware that if you use insurance I will be required to provide a diagnosis on invoices and claims, and coverage may be limited to certain mental conditions that are covered by your plan.
	LIMITS OF MEDICAL COVERAGE: Even if you have insurance coverage for unlimited sessions, health plans may review treatment for medical necessity, limit length of treatment or frequency of sessions, and request treatment notes. While I may check coverage for you, you are responsible for verifying and understanding the limits of your coverage. Although I am happy to assist your efforts in obtaining insurance reimbursement, I am unable to guarantee whether your health plan will provide payment for the services provided.
	CONFIDENTIALITY: What you say in therapy, your records, and your attendance are all confidential. Exceptions to confidentiality include when your records are subpoenaed for legal reasons, and when reporting is required or allowed by law. The law requires reporting of suspicion of child abuse or neglect; bullying; when there is downloading, streaming, or accessing material in which a child is engaged in an obscene or sexual act; danger to self; suspected

	elder abuse; and suspected danger to others. Other exceptions to confidentiality are when you give written permission to release information. See other exceptions outlined in my *Notice of Privacy Practices.*
	IN AN EMERGENCY: . You must go to the emergency room or dial 911.
	E-MAIL/SOCIAL MEDIA: Please do not e-mail me information related to your therapy, as e-mail is not completely confidential, and Important issues should be reserved for sessions. Be aware that e-mails between us become part of your legal record. I do not accept friend requests or contact requests from clients on social networking sites (Facebook, LinkedIn, etc.) out of concern for your confidentiality and my privacy. It may also blur the boundaries of our therapy relationship. *(continued)*

INITIAL BELOW	*Treatment Agreement (continued from Page 1)*
	LEGAL MATTERS: If you become involved in legal proceedings that require my participation, you agree by signing this Agreement to pay me at my regular full fee of $___175______per hour for any time I must spend on your case, including but not limited to time spent to appear in court or give depositions, and lost income for sessions I must miss.
	REFERRALS/GROUP: A referral to another provider may become necessary if it becomes clear in my opinion that your issues would be better treated by a professional with different expertise. It is unethical for me to practice beyond the level of my competence, education, training, or experience. I am not responsible for the care received from professionals to whom I refer you. Agreements made between you and I do not involve other professionals in the office suite, who each operate independent solo practices, and are not part of a group
	ENDINGS: If you are unhappy with any aspect of therapy, please don't just leave – I ask that you talk to me to see if we can work it out. Even if we can't, endings usually feel better this way. Of course, you may end therapy at any time, and I am happy to assist with referrals. It is my ethical duty to provide therapy only when I feel you are actively participating and benefiting from the sessions. I may end treatment if there have been repeated no-shows, late-cancellations or other treatment interruptions.
	PATIENT RIGHTS: You have the right to ask any questions about your treatment or refuse to participate in treatment at any time. This office does not discriminate in the delivery of health care services based on race, ethnicity, national origin, citizenship or immigration status, religion, gender/gender identity, age, mental or physical disability, medical condition, sexual orientation, medical history, evidence of insurability, or source of payment.
	PRIVACY PRACTICES: By initialing here and signing below, you are acknowledging receipt of my *Notices of Privacy Practices*. My *Notice of Privacy Practices* provides information about how I may use and disclose your private health information. I encourage you to read it in full. My *Notice of Privacy* Practices is subject to change. If I change my Notice, I will give you a revised Notice. If you have left treatment, you may obtain the revised notice from me at the above address and phone number

PLEASE SIGN THE FOLLOWING IF USING YOUR INSURANCE OR EMPLOYEE ASSISTANCE PROGRAM:

"I authorize the release of any information necessary (Including notes, treatment summaries and diagnosis) to process insurance or Employee Assistance claims, to prove medical necessity for treatment, to request additional sessions, or to comply with treatment reviews or mandated administrative chart reviews from the insurance plan."

(Sign here) :**X** ____

If second client participating, sign here: **X** ____

"I authorize payment of benefits to my therapist" (Sign here): **X** __________________________

If you have any questions about any of the above, please feel free to ask.
By signing below, I acknowledge that I have read and understand the above rights and policies.

Signature	Printed Name	Date
Signature, second client (if applicable)	Printed Name, second client (if applicable)	Date

CLIENT NAME______________________________

TELEHEALTH (VIDEO/PHONE) COUNSELING AGREEMENT

The purpose of this form is to obtain your consent to participate in telemental health, which involves counseling by phone, video, or secure online email portal.

Benefits include:

1. It's more convenient. It can decrease the time commitment of therapy since there is no travel time
2. I can see you even if you are unable to get to my office (ex. transportation issues), if you are home sick, or when you are home caring for an ill family member
3. I can see you when you travel within the state, or even when you move within the state
4. You can always choose to schedule a face-to-face session, when desired

Limitations/Risks include:

1. There is a greater chance of misunderstanding -- due to technology limits, I might not see some of your body language or hear subtle differences in your tone of voice that I could easily pick up if you were in my office. And you might not pick up mine.
2. If we meet in-person, I have more control of interruptions. With video, I can't control your setting.
3. Internet connections could cease working or become too unstable to use
4. The telehealth platform or our computers/smartphones can have sudden failure or run out of power
5. You may feel more emotional distance related to the lack of in-person contact and presence.
6. I cannot guarantee the privacy/confidentiality of conversations held via phone, as these can be intercepted accidentally or intentionally. I cannot guarantee that hackers will not access video calls.
7. I cannot immediately intervene in-person if you are in crisis.

Logistics

1. If we are connecting by phone, I will call you at our scheduled time.
2. I will be in a private location where I am alone in the room. You also need to be in a private location where you can speak openly without being overheard or interrupted by others to protect your own confidentiality. If you choose to be in a place where others can hear you, I cannot be responsible for your confidentiality.
3. At the start of the session, I may verify your location (street address). This enables me to send help, if needed, and to verify that you are in-state. I can only provide therapy to you while you are in the state where I am licensed. If I do not ask, please be sure to tell me if you are not at your home.
4. Do not invite others to join us for any part of the session without discussing this with me in advance.

(continued)

CLIENT NAME_______________________________

You may have a better experience if you:

1. Make sure your device is fully charged.
2. Wear a two-ear headset with microphone (this can help us hear each other)
3. Consider how you will reduce interruptions (ex. talking to family in advance about your need for privacy during that hour, using a "do not disturb" sign on your door, etc.)

Connection Loss:

- **Billing for a disrupted session:** If the disconnection is due to my service or equipment, I will not charge you for the session, or will prorate it for what time we talk. If the disconnection is due to your service or equipment, you will be charged in full for the session (not just a copayment).

Security

- It is not recommended that you communicate using a public wireless network.
- You represent that you are not using someone else's device or your employer's computer, since employers have the right to monitor their equipment and networks, which could compromise your privacy.
- You have the sole responsibility for security and privacy of your devices, equipment, and internet connection.

Recording of Sessions:

- No sessions will be recorded by me, and the telehealth platform I use states that there is no recording of the session, no information collected, and no digital record saved afterwards. Please note that recording or screenshots of any kind of any session are not permitted, and are grounds for termination of the client-therapist relationship.

Payment for Services:

Payments for services must be made prior to our session or the day of the session. I will charge your credit card on file on the session date. If you prefer not to use a credit card, you may pre-pay for sessions ahead of time by check or cash. If you have insurance and I am on your insurance provider list, I will bill insurance on your behalf, but you remain responsible for any portion they do not pay.

(continued)

(Telehealth Consent, continued)

Session Cancellations:

Phone/video sessions are treated as in-office sessions when it comes to late cancellations and no-shows -- 24-hour advance notice is required, otherwise you will be charged the full session fee (not just a copayment), except for cases of unforeseen medical emergency. Cancellations should be communicated via email and phone.

Emergencies and Confidentiality:

Since you will be at a distance, please list an emergency contact for you:

____

Full Name | Relationship | Phone Number(s)

If you do not expect to be at home for sessions, please give the location you expect you will be:

Street Address____

Emergency (continued):

If you are outside the area that I practice at the time of our session, I will identify emergency resources in your area and document that in your chart. If you are in crisis and we get disconnected, you agree to call 911, go to your local emergency room immediately or contact the National Suicide Hotline at 800-784-2433 if you cannot reach me.

Please share with me if you have severe feelings of helplessness, hopelessness, or wanting to hurt yourself or others. There are many steps I can take to help, even at a distance. However, if I have extreme concerns about your safety at any time during a phone session, we may need to have you come to the office, or I may need to call your support system or emergency services to keep you safe.

Please note that everything in our informed consent that you signed, including all the confidentiality exceptions, still applies during phone/video sessions.

Consent to Participate in Telehealth Sessions

By signing below, you agree that you have read and understand all of the above. You give permission for me to communicate with your emergency contact if client is concerned about your safety. You agree that you have had the chance to ask questions, that you understand the limitations associated with participating in telehealth sessions and consent to attend sessions under the terms described in this document.

Signature: ____

Printed Name: ____