PRESSMAN AND ASSOCIATES
INFORMED CONSENT

Welcome to the practice. We look forward to working with you. Please review the following information, and sign at the end to acknowledge your agreement with what you have read.

1. Confidentiality: Your confidentiality will be strictly maintained at all times. If you want information released to other professionals of your choosing, I will give you a release form for your signature.

The exceptions to confidentiality are as follows: If you inform me of your intention to commit a crime, to injure yourself or another, of your own or another's physical or sexual abuse of a child, or if in my judgment you are unable to care for yourself or maintain your safety, I am legally bound to inform the appropriate authorities. Further, if I receive an official subpoena for your records or am court-ordered to provide information about you, again I must comply with the law. Finally, in the interest of helping you receive insurance reimbursement, I will provide the minimum information required toward this end.

2. Availability: I do not carry a beeper, but check my messages regularly. In case of emergency where you are not able to reach me, you are responsible for finding the appropriate help (local emergency room, etc.). I will give you plenty of notice if I will be away, and, while I do not usually provide coverage during these times, I can give you the phone number of someone to call if you request it. I do not have extensive back-up, and cannot hospitalize people.

3. Cancellations: Please give me maximum cancellation notice when at all possible. Please understand that when you schedule an appointment, we reserve that time for you. Without sufficient notice, we are unable to offer the slot to someone else who may need it. During winter months, when weather is questionable, please call the office. A recorded message will tell you whether we will be open or not.

4. No-harm contract: You agree, unequivocally, not to attempt to harm yourself or another person for the duration of our therapy together. You further agree to discuss any thoughts or feelings about doing so with me in our sessions.

5. Termination: Either one of us can terminate our working arrangement at any time. You agree that you have entered this therapy freely and of your own choice. You also understand that you are free to leave at any time, though any unresolved concerns should be addressed as part of the therapy before terminating. When appropriate or when you request it, I will help you find another therapist.

I have read and understood this document, discussed any questions with the therapist, and agree to abide by the terms and policies expressed here.

Signature of client: _____ Date: _____

Signature of therapist: _____ Date: _____

Assignment of Benefits

Patients _____

Ins. Company _____

Policy, Group _____

SS # / ID #/ Claim #_____

I hereby authorize the _____ **Insurance Company to pay by check made out and mailed to:**

Pressman & Associates, LLC
PO box 43 Swartswood, NJ, 07877

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said Professional Service charges and above this insurance payment.

If my current policy prohibits direct payment to Pressman & Associates, LLC, I hereby also authorize you to make the check to me and mail it as follows:

c/o:
Pressman & Associates, LLC
PO box 43 Swartswood, NJ, 07877

I also hereby assign to Pressman & Associates, LLC all of my rights to obtain payment under the personal injury protection provisions or an automobile insurance policy or any other health insurance policy of any medical bills incurred as a result of my treatment, including the option to submit any dispute in my name to binding arbitration under the auspices of the Forthright arbitration process or any other form that the provider deems appropriate.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Date _____

_____

Signature of Policy Holder

_____

Signature of Claimant, if other than Policy holder

Pressman and Associates, LLC

900 Haddon Ave, Ste 122, Collingswood, New Jersey 08108

856-548-9557 mrosario@pippna.com

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Notice of Privacy Practices for the practice of Pressman and Associates, LLC. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Pressman and Associates at 856-548-9557.

_____

Signature of Patient/Client **Date**

_____

Signature or Parent, Guardian or Personal Representative * **Date**

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Signature of Staff Member **Date**

Pressman and Associates, LLC
P.O. Box 43
Swartswood, NJ 07877
856-548-9557
For medical records send email attention: Ms. Helaine Banghart,
helaine@cbcbilling.com or fax: 973-827-3588

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, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. 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.

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.

As a mental health professional in this state, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with HIPAA.

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, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI 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 or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

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 at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to us at Pressman and Associates, 703 Sheppard Road, Voorhees, New Jersey 08043:

- **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 or if the information is contained in separately maintained psychotherapy notes. 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. You may also request that a copy of your PHI be provided to another person.
- **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 health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI 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 us at 703 Sheppard Road, Voorhees, New Jersey 08043 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.**

The effective date of this Notice is September 2014.

Pressman and Associates, LLC
P.O Box 43 Swartswood, New Jersey, 07877
Phone: 856-548-9557

POLICY FOR NO SHOWS/LATE CANCELLATIONS

Dear valued client,

When you book an appointment with our office, we reserve that time specifically for you. If you forget to show up or cancel without sufficient notice, we are unable to give that time to another patient who needs it. Furthermore, it prevents us from being able to fully help you in your recovery, as consistent weekly sessions of **both** the services you are receiving are essential.

To support you in keeping your appointments, we are implementing the following policy:

If you forget your appointment or cancel with less than 48 hours' notice, we will charge a $35 cancellation fee. Of course, this does not apply in the case of a medical emergency or other situation that is truly unavoidable. (Note: this fee is not something your insurance can cover).

Please make every effort to schedule other appointments around your therapy time, remembering this is a medical appointment and is essential for your recovery.

Thank you for your understanding as we strive to make this practice the best it can possibly be for your full recovery, health and well-being!

Please sign and date your acknowledgement below:

Name (signature) _____

Name (printed) _____

Date _____

Name:_____ Date:_____

Pressman and Associates
900 Haddon Ave, Ste 122, Collingswood, New Jersey 08108
Phone: 856-548-9557 Fax: 888-448-7583

HAVE YOU BEEN IN A CAR ACCIDENT? TAKE THIS TEST!

Please enter the number between 1 and 5 that best describes how you have been feeling since the time of the accident. 1 means "almost never or not at all" and 5 means "almost always or very much".

Since the accident:

1) I have more anxiety about driving
2) I have more anxiety in general

3) I avoid:
- being in a car
- being the driver
- being the passenger
- driving at night
- driving in the rain or snow
- driving in heavy traffic
- driving on highways
- driving past the scene of the accident

4) I have nightmares and/or flashbacks about the accident
6) I'm isolating more from people, not getting out as much
7) I'm sleeping more or less than usual
8) I'm sometimes irritable and short-tempered
9) I'm eating more or less than usual
10) I cry or feel like crying more than before
11) I have more muscle tension than before
12) My sex drive is decreased
13) I'm having more struggles in my relationship
14) I'm having difficulty keeping up with daily activities
15) I feel more pessimistic about the future
16) Things which used to give me pleasure don't now

PLEASE TOTAL YOUR SCORE.....TOTAL: _____

NOTE: IF YOU SCORED 31 OR HIGHER, IT COULD INDICATE A SERIOUS CONCERN. PLEASE TAKE THIS IN TO YOUR APPOINTMENT AND ASK ABOUT AN EVALUATION WITH A PROFESSIONAL WHO CAN HELP, OR CALL PRESSMAN AND ASSOCIATES AT 856-548-9557