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Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_



## Family Service Bureau of Newark

Newark Office: 274 South Orange Avenue, Newark, New Jersey 07103

Tel: 973-412-2056 Fax: 973-484-3452

West Hudson Office: 379 Kearny Avenue, Kearny, New Jersey 07032

Tel: 201-246-8077 Fax: 201-955-6165

[www.newcommunity.org](http://www.newcommunity.org)



### Client Rights

1. You have the right to be informed of these rights, and receive a written explanation of these rights.
2. The right to be free from unnecessary or excessive medication (see NJAC 10:37-6.54).
3. The right to be notified of any rules and policies the program has established governing client conduct in the facility.
4. The right to not be subjected to non-standard treatment or procedures, experimental procedures or research, or provider demonstration programs, without written informed consent. If the client has been adjudicated incompetent, authorization for such procedures may be obtained only pursuant to the requirements of NJSA 30:4-24.2(d)2.
5. You have the right to be informed of services available in the program, the names and professional status of the staff providing and/or responsible for your care, fees and related charges for services not covered by insurance.
6. You have the right to receive an explanation of your complete medical/health condition or diagnosis, recommended treatment, progress, treatment options including the option-of no treatment, risk(s) of treatment and expected result(s) of treatment:
  - The Psychiatrist or Director may determine this information may place a client at risk, the explanation shall be provided to a family member, legal guardian, or significant other as available.
  - A release of information to a family member, legal guardian or significant other, along with the reason for not informing the client directly, shall be documented in the client's clinical record.
  - All consents to release information shall be signed by client or their parent, guardian or legally authorized representative.
7. You have the right to privileged communications with those who treat you; information you provide may not be disclosed unless you consent.
  - Your clinical record shall not be released to anyone outside the program without your written approval to release the information in accordance with the Federal statutes and rules for the Confidentiality of Alcohol and Drug Abuse Client Records, unless the release of information is required and permitted by law, a third-party contract, a peer review, or information needed by DAS for authorized purposes.
  - This program may release data about you for studies containing data only when your identity is protected and masked.
8. You have the right to be informed if the program has authorized other health care or educational institutions to participate in your treatment and have the right to refuse their involvement into your treatment.
9. The right to treatment in the least restrictive setting, free from physical restraints, corporal punishment, and isolation.
10. You have the right to be treated with courtesy, consideration, respect, and with recognition of your dignity, individuality and right to privacy, including but not limited to auditory and visual privacy.
11. You have the right to exercise civil and religious liberties, including the right to independent personal decisions.
12. You have the right to not be discriminated against because of age, race, religion, sex, nationality, sexual orientation, disability (including, but not limited to, blind, deaf, hard of hearing), or ability to pay; or to be deprived of any constitutional, civil, and/or legal rights.



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13. The right to refuse medication, treatment, and/or decline the recommendation of treatment made by this agency.

- You will not be discriminated against for taking medications as prescribed.

• Prescribed medications shall not be withheld for failure to comply with facility rules or procedures, unless the decision is made to terminate the client; medications may only be withheld when the facility medical staff determines that such action is medically indicated.

14. The right to participate in the development of your treatment plan.

15. The right to access and obtain a copy of your record, in accordance with agency policies and applicable federal and state laws: you have a right to add to or request a modification of your treatment record.

16. You have the right to be transferred or discharged only for medical reasons, for your welfare, that of other clients or staff upon the written order of a physician or licensed clinician, or failure to pay required fees as agreed at time of admissions (except as prohibited by sources of third-party payment).

17. Your transfer and/or discharge, and the reason will be documented in your clinical record.

18. You will receive 10-day advance notice of such transfer/discharge for non-emergency discharges planned by the treatment program.

19. You have the right to be notified in writing, and to have the opportunity to appeal, an involuntary discharge.

20. You have the right to voice grievances or recommend changes in policies and services to program staff, the governing authority; and/or outside representatives of your choice, free from restraint, interference, coercion, discrimination or reprisal.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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### **Family Service Bureau (FSB) of Newark Intake Agreement/Consent for Services**

#### **Cancellation Policy**

It is the policy of the Family Service Bureau of Newark that you must give at least 24 hours of notice prior to your scheduled appointment of your intent to cancel/reschedule or be subject to a \$25 late cancellation fee. Rescheduling appointments will be at the discretion of your therapist and Director. Please be advised that two cancellations and/or excessive rescheduling will be reviewed to determine if your termination of services is appropriate. Referrals to other services will be supplied to you upon termination.

#### **No Show Policy**

An appointment no show will result in a \$25 no show fee. No future appointments will be scheduled until the fee has been paid. After 10 business days of non-payment your case will be closed. Please be advised that two no shows will result in termination from the program. Referrals to other services will be supplied to you upon termination.

#### **Medication Policy**

FSB only provides medication services to individuals who are enrolled in and consistently receive psychotherapy services through FSB. You must receive weekly or bi-weekly psychotherapy to receive medication services.

#### **Service Limitations and Length of Stay**

If it is determined that you do not qualify for services under the program or you cannot be adequately treated by the program, you will be referred to another community program, agency or individual who can better address your needs. Please be advised that services at FSB are considered short-term. Treatment will complete on or before 18 months of service. Upon completion you will be referred to other services, if applicable.

#### **Conflicts of Interest**

Should a conflict of interest arise, you will be referred to another appropriate treatment source, up to and including referral to a different agency.

#### **Medical Records**

An electronic/paper record is maintained regarding your care and treatment. This documentation includes, but is not limited to, the following: a behavioral health assessment, progress notes and treatment plans.

#### **Psychiatric Evaluations**

Within your first 30 days at FSB, you will be scheduled for a psychiatric evaluation. Please note that substance abuse clients will only be scheduled if deemed necessary by their assigned clinician.

By signing below, I indicate that I have read, understand and agree to the terms of the intake agreement and consent of services.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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### **Disclosure Regarding Provision of Counseling Services**

Client Name: \_\_\_\_\_

In accordance with the New Jersey Office of the Attorney General, Division of Consumer Affairs State Board of Marriage and Family Examiners Alcohol and Drug Counselor Committee and Professional Counselor Committee (Herein after referred to as “the state licensed body”) Statutes and Regulations, Family Service Bureau of Newark has advised me of the following:

In accordance with Regulation N.J.A.C. 3:34 C-6.2(c), N.J.A.C. 13:34-13.1(g) and N.J.A.C. 13:34-3.3 (b), I understand that I may receive counseling services from a clinician who is not a (Licensed) Certified Alcohol and Drug Counselor (L)CADC, Licensed Professional Counselor or Licensed Marriage and Family Therapist; however, this individual shall remain under the clinical supervision of an appropriately licensed/certified supervisor as per Regulation N.J.A.C. 3:34 C-6.2(c), N.J.A.C. 13:34-13.1(g) and N.J.A.C. 13:34-3.3 (b).

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**An original copy of this form will be placed in client’s file.**



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### Advanced Directive

On January 11<sup>th</sup>, 1992, a New Jersey law took effect, which mandates that all health care facilities ask patients whether they have an Advanced Directive or Living Will. At Family Service Bureau of Newark, we have made this part of the admission process.

If you have an Advanced Directive, please bring it to Family Service Bureau upon your next visit.

If you do NOT have an Advanced Directive, please read the following information. An Advanced Directive is a document which allows you to give written instructions to those caring for you indicating the type of health care you wish to receive or reject in the event that you become unable to express these decisions yourself. There are three (3) different types of Advanced Directive:

1. *Proxy Directive*

This is a document in which a competent adult names a trusted relative or, friend to make health care decisions on their behalf when they are unable to make these decisions.

2. *Instructive Directive*

In this document, the person writing provides written instructions concerning the type of medical treatment they want performed for them and under what circumstances.

3. *Combined Directive*

In this document, a competent adult states their general wishes regarding the kind of health care they wish to receive but appoints a trusted relative or friend to carry them out.

A brochure containing Living Will information is available from the Division of Aging. If you wish to receive this brochure, please make your request to:

The Division of Aging, 101 South Broad Street, CN807, Trenton, New Jersey 08625

Do you have an Advanced Directive? ☐ Yes ☐ No

*If yes, please bring a copy to Family Service Bureau on your next visit.*

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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### Family Intervention Screen

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

☐ I would like the following family/friends involved in the treatment:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Or,

☐ At this time, I do not wish to have family/friends involved in my treatment. However, I do understand the potential benefits that increased support from family/friends could have on successful treatment outcomes. I may consider family involvement in the future.

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

Please initial one of the following statements:

\_\_\_\_\_ I consent

\_\_\_\_\_ I do NOT consent

to allow Family Service Bureau of Newark, permission to send me a Follow-up Discharge Letter/Survey.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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### Safe & Drug Service Agreement

Family Service Bureau is committed to providing services in a safe and drug-free environment. For everyone's safety, any person suspected of being impaired or under the influence of any substances will not be seen at that time and another appointment will need to be scheduled.

Family Service Bureau recognizes the tremendous toll that substances take on the person who suffers from addictive disorders and their families. We are fully committed to providing a safe place for those who wish to address substance issues — to speak in full confidence. Use of substances does NOT preclude anyone from receiving services at this Agency. All our services are in full compliance with HIPPA and Federal Confidentiality laws — 42: CFR part 2.

#### Policy:

Any person suspected of being “*impaired*” or “*under the influence*” of any mind or mood altering substances will be asked to contact a family member or friend to escort them from the premises to insure that they arrive home safely. If no one is available to provide transportation or escort, a cab will be called *at the expense of the client*.

A suspicion of “*impaired*” or “*under the influence*” means that the clinician or any staff member can visibly see that the client is having difficulty with gross motor movement or can smell substance use (alcohol or other substance).

No person will be permitted entry into “group”, nor will the staff member be able to provide services at this time. Any person who presents with significant impairment, will be treated as a medical emergency and an ambulance will be called to take him/her to the local Emergency Room.

I have read the Safe & Drug-Free Services Agreement and have had the opportunity to discuss with my counselor. I understand, and agree to abide by this policy.

Client Name: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_





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### Consent to Obtain/Release Information

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

I authorize (FSB Therapist) \_\_\_\_\_ Therapist on record \_\_\_\_\_ to correspond with:

Person/Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**To OBTAIN the following information and/or RELEASE the following information:  
Please initial where applicable**

- |                                   |  |
|-----------------------------------|--|
| ____ Psychosocial Evaluation      | ____ Psychiatric/Psychological Records |
| ____ Intake/Admission Summary     | ____ Treatment Plans/Recommendations   |
| ____ Closing/Discharge Summary    | ____ Probation/Parole Records          |
| ____ School Records               | ____ Medical Records                   |
| ____ Child Study Team Evaluations | ____ Drug Screen Results               |
| ____ Other: _____                 |  |

For the purpose of: \_\_\_\_\_

I voluntarily choose to sign for the purpose(s) specified above. **This release will expire in 1 year of date signed unless otherwise specified.** I further understand that I may cancel authorization for release of information at any time unless the information has already been sent. Unless otherwise specified any permission to release the above information will expire within 4 weeks following conclusion of treatment.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date



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### **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.**

Family Service Bureau of Newark is providing this Notice of Privacy Practices because the privacy of your health information is very important to you and to us, and in compliance with federal regulations.

By “your health information” we mean the information that we maintain that specifically identifies you and your health status.

#### **Summary**

This Notice describes how we use your health information within Family Service Bureau and disclose it outside Family Service Bureau, and why.

This Notice covers:

- Uses or disclosures that do not require your written authorization.
  - Treatment, payment, and health care operations.
  - Uses or disclosures of your health information to which you may object.
  - Uses or disclosures required or permitted.
- Uses or disclosures that require your written authorization.
- Your rights as a patient regarding privacy of your health information.
- Our duties in protecting your health information.
- Complaints, contact person, effective date, and acknowledgement.

#### **USES OR DISCLOSURES THAT DO NOT REQUIRE YOUR WRITTEN AUTHORIZATION**

##### **Treatment, Payment, and Health Care Operations**

We use or disclose your health information to carry out your treatment; to obtain payment for your treatment; and to conduct health care operations. For example:

- For treatment, we use your health information to plan. Coordinate, and provide your care. We disclose your health information for treatment purposes to physicians and other health care professionals outside our agency who are involved in your care.
- For payment, we use your health information to prepare documentation required by your insurance company or HMO or by Medicare or Medicaid. We disclose that part of your health information that these organizations require to pay us.
- For health care operations, we use or disclose your health information, for example, to improve the quality of our services, to plan better ways of treating patients, and to evaluate staff performance.

#### **Uses or Disclosures of Your Health Information to Which You May Object**

We may use or disclose your health information for the following purposes, unless you ask us not to.

- Informing family and friends. We may disclose your health information to family, friends, or others identified by you who are involved in your care with a signed consent from you.
- Assistance in disaster relief efforts.
- For fundraising activities. We may contact you or your family for fundraising purposes. If you do not wish to be contacted for this purpose, please contact and indicate that you do not wish to receive fundraising communication from us.
- Confirming your appointments.



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- Informing you about treatment alternatives or other health related benefits and services that may be of interest to you.

If you object to our use of your health information for any of these purposes please contact:

Privacy Officer

Family Service Bureau of Newark

973-412-2056

### Uses or Disclosures Required or Permitted

Where we are required or permitted to do so, we may use or disclose your health information in the following circumstances without your written authorization.

- If a consumer voices a threat against a specific individual or group, that individual or person responsible for the group (e.g., school principal if the threat was made against a school) must be notified. Police may be notified if the intended victim cannot be notified. [practitioners have a duty to warn],
- If a consumer reveals that child abuse may have taken place, the Division of Child Protection and Permanency must be notified [10:37-6.108(b)]
- If the consumer is a minor suspected of being abused, the record may be released to DCPNP [10:37-6.79(c)]
- If a consumer reveals abuse on a rooming/boardng/nursing home, this shall be reported to the County Welfare Agency [10:37-6.108(b)],
- Information may be shared with another mental health agency in accordance with HIPAA [10:37-6.79 (b)1i]
- If a judge orders the release of information to a court [10:37-6.79(a)2],
- If a consumer is psychiatrically evaluated by a psychiatric screening center, information may be released to the screening staff to facilitate the evaluation [10:37-6.79(a)3]
- To comply with any Federal or State law requiring the release of information [10:37-6.79(a)3]
- When the Office of Licensing or Medicaid conducts a review, a consumer's clinical record may be reviewed [10:37-6.79(b)2]
- An accreditation reviewer may look at a consumer's record [10:37-6.79(b)3]
- If officials within the offices of the State Medical Examiner or a County Medical Examiner making investigations and conducting autopsies request the information [10:37-6.79(b)4]
- Non-specific information may be provided to a family member or friend if the consumer does not object [N.J.A.C. 10:37-6.79(e)];
- To a consumer's personal physician to benefit the consumer [N.J.A.C 10:37-6.79 (f)]
- Medication information may be released to the consumer's pharmacy under the age of 18 requiring authorization will be determined by the consumer's parent or guardian [N.J.A.C. 10:37-6.79(a)1ii(2)]

### Uses or Disclosures Which Require Your Written Authorization

Your written authorization, which you may revoke (in writing), is required if we use or disclose your health information for any purpose other than those stated above. In particular your authorization is required if:

- We use or disclose your psychotherapy notes other than for treatment or health care operations specified in federal regulations.
- We use or disclose your health information for marketing or goods or services.

### Your Rights as A Patient to Privacy of Your Health Information

- **Right to Request Restrictions**

You have the right to request restrictions on our uses and disclosures of your health information, however we may refuse to accept the restriction.

- **Right to request an Accounting of Disclosures of Your Health Information**

You have the right to request an accounting of our disclosures of your health information for purposes other than treatment, payment, and health care operations. We will make every attempt to honor your request. We are not



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required to provide an accounting for disclosures before April 13, 2003 or for more than 6 years prior to the date of your request.

- **Right to Obtain a Paper Copy of this Notice**

If you have received this Notice electronically, you have the right to receive a paper copy. To exercise any of these rights please write or telephone our offices at 274 South Orange Avenue Newark, NJ 07103, (973) 412-2056 or 379 Kearny Avenue, Kearny NJ 07032, (201) 246-8077.

### **Our Duties in Protecting Your Health Information**

- We are required by law to maintain the privacy of your health information
- We must inform our patients or their legal representatives of our legal duties and privacy practices with respect to health information. This notice discharges that duty.
- We must abide by the terms of the Notice currently in effect.
- We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that we maintain. At any time, you may obtain a copy of the current notice from our Privacy Officer, or the person designated by said officer.

### **Complaint, Contact Person, Effective Date, and Acknowledgement**

- You may complain to us and to the Secretary of Health and Human Services if you believe your rights have been violated.
- You will not be retaliated against for filing a complaint.
- You may file your complaint with our agency by writing to our Privacy Officer at 274 **South Orange Avenue Newark, NJ 07103** or calling **(973) 412-2056**.
- You may file a complaint with the Secretary of Health and Human Service by writing to:

Secretary of Health and Human Services

U.S. Department of Health and Human Services

200 Independence Avenue S.W.

Washington, D.C. 20201

(Source: [www.hhs.gov](http://www.hhs.gov))

- For further information you may write or call our Privacy Officer at:  
**274 South Orange Avenue, Newark, NJ 07103** or by calling **(973) 412-2056**.
- This notice is effective April 14, 2003.



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### **Notice of Privacy Practices**

#### ***Acknowledgement of Receipt***

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

A copy of the Family Service Bureau's Notice of Privacy Practices has been given to me.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If personal representative:

Name: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

---

Reason signature not obtained:

☐ Client too sick at this time

☐ Client would not sign

☐ Other: \_\_\_\_\_

Name of Family Service Bureau employee attempting unsuccessfully to obtain signatures:

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_



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### **GRIEVANCE, COMPLAINT, SUGGESTION**

#### ***Policy & Procedure***

If you are unhappy with the services that you have received at the Family Service Bureau of Newark, you are entitled to a fair hearing with a staff member so that your complaint can be resolved to your satisfaction. If you have spoken with the staff person and feel that you cannot resolve the problem, you can speak to the supervisor. If your problem is still not resolved, then you can begin more formal complaint proceedings. Upon intake at FSB, clients are given Statewide advocacy services available to them [N.J.A.C. 10:37-4.6(b) 1]; however, if this is internal the grievance process at FSB is as follows:

1. Notify the staff person that you wish to file a complaint or grievance.
2. Staff will immediately notify the Clinical Supervisor.
3. The Program Director will notify the Agency Ombudsperson.
4. The Agency Ombudsperson will receive the complaint and act as your advocate. This person will attempt to negotiate a resolution of the issues within five (5) working days of receipt of the complaint.
5. If you feel that your complaint still has not been resolved, your complaint will be forwarded to the Executive Director of the Family Service Bureau of Newark. for review and resolution. The Executive Director will make the final resolution for the agency within seven (7) working days of receiving the complaint.
6. If you continue to be dissatisfied you can request a review from the County Mental Health Board. The Executive Director will notify the Mental Health Board Administrator within five (5) working days.
7. The County Mental Health Board will review your complaint and will inform the Executive Director of its recommendations within seven (7) working days.
8. If you remain unsatisfied, you may request a review by the New Jersey Division of Mental Health and Addiction Services.
9. These actions will not result in retaliation or barriers to services in anyway.

At any time during this process, you may contact an outside agency.

I have read and understand the Grievance Procedures. I have received a Grievance Procedure List for Essex County.

---

Client Signature

Date

---

Staff Signature

Date



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### Client Advocacy Resources

Resources	Phone Number
<b>Community Mental Health Law Project</b> <u><a href="mailto:Bloomfield@chlp.org">Bloomfield@chlp.org</a></u>	<b>973-680-5599 or 973-275-1175</b> <i>650 Bloomfield Avenue, Suite 210 Bloomfield, New Jersey 07003</i>
<b>Community Mental Health Administrator(s)</b> <u><b>Essex:</b></u>  <u><b>Hudson County:</b></u>	<b>973- 571-2821 or fax 973 -571- 2820</b> <i>Joseph Scarpelli, Administrator Essex County Department of Health 204 Grove Avenue, Cedar Grove, NJ 07009</i> <u><a href="mailto:Jscarpelli@helath.essexcountynj.org">Jscarpelli@helath.essexcountynj.org</a></u>  <i>Robin F. James, MA Dept. of Health &amp; Human Services 830 Bergen Ave, 2B Jersey City, NJ 07306 Phone: (201) 369-5280, ext. 4250 E-mail: <a href="mailto:rjames@hcnj.us">rjames@hcnj.us</a></i>
<b>Adult Protective Services</b> <b>Essex County:</b> <i>Focus, Hispanic Center for Human Development Inc. 441-443 Broad Street Newark, New Jersey 07102</i>	<b>866-903-6287</b> <i>After hours: 911 or local police</i>
<i>Hudson County Adult Protective Services 6100 Adams Street West New York, NJ 07903</i>	<b>201-537-5631</b> <i>After hours: 911 or local police</i>
<b>Disability Rights New Jersey</b> <i>210 South Broad St. 3<sup>rd</sup> Floor Trenton, NJ 08608 <u><a href="http://www.drnj.org">www.drnj.org</a></u></i>	<b>800-922-7233</b>
<b>Division of Mental Health and Addiction Services</b> <b>Special Assistant for Consumer Affairs</b> <b>Margaret Molnar</b> <b>5 Commerce Way</b> <b>Hamilton, NJ</b>	<b>609-438-4338</b>
<b>Division of Mental Health Advocacy</b> <b>State of New Jersey</b> <b>Richard J. Hughes Justice Complex</b> <b>25 Market Street</b> <b>Trenton, NJ 08626</b>	<b>877-285-2844</b>



## Family Service Bureau of Newark

Newark Office: 274 South Orange Avenue, Newark, New Jersey 07103  
Tel: 973-412-2056 Fax: 973-484-3452  
West Hudson Office: 379 Kearny Avenue, Kearny, New Jersey 07032  
Tel: 201-246-8077 Fax: 201-955-6165  
[www.newcommunity.org](http://www.newcommunity.org)



**Division of Child Protection and Permanency**  
**(Formerly Division of Youth and Family Services)**  
**(Essex County Office – DCP&P)**  
**153 Halsey Street, Newark, NJ 07101**

**973- 648-4200**  
**1-800-392-9532**  
**201- 795-0423 (Hudson)**

*(Hudson County Office- DCP&P)*  
*Jersey City, NJ 07306*  
*438 Summit Avenue, 4<sup>th</sup> Floor*  
*Jersey City, NJ 07306*

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**Essex County Welfare Agency**  
*Essex County Dept. of Citizen Services Division of*  
*Welfare*  
*18 Rector Street, 9th fl.,*  
*Newark, NJ 07102*

**973- 733- 3000**

**Hudson County Welfare Agency**  
*Hudson County Department of Family*  
*Services 257 Corenelison Ave.*  
*Jersey City, NJ 07302*

**201-420-3000**

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**Division of Mental Health and Addiction Services**  
*Northern Regional Office*  
*100 Hamilton Plaza, Box 4*  
*Paterson, NJ 07505*

**973-977-4397 or 1-800-382-6717**

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**Protection & Advocacy of New Jersey**  
**(formerly Public Advocate's Office)**  
**[advocate@njpanda.org](mailto:advocate@njpanda.org)**

**800-922-7233 (statewide)**  
**609 -292 -9742**  
*NJ Protection and Advocacy, Inc.*  
*210 So. Broad Street, 3rd fl.,*  
*Trenton, NJ 08608*

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**Legal Services of New**  
**Jersey 5 Commerce St.**  
*Newark, NJ 07102*

**973- 624-4500**

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**NAMI-New Jersey**  
*1562 Route 130*  
*North Brunswick, NJ 08902*  
**[www.naminj.org](http://www.naminj.org)**

**732-940-0991**  
**Email- [info@nami.org](mailto:info@nami.org)**

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**New Jersey Self –Help Group Clearinghouse**  
*673 Morris Ave. Suite 100*  
*Springfield, New Jersey 07081*

**800-367-6274**

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**Child Abuse/Neglect Hotline**

**1- 877-652-2873**

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### **Office Policies and Privacy Notice**

#### **Length and Nature of Appointments**

During your first visit, you will be asked about your reasons for seeking mental health / psychiatric or substance abuse treatment and your goals for the future. After the initial visit, your appointments will last between 30 and 45 minutes depending on the nature of your treatment. At the end of the initial consultation appointment, your clinician provides a clinical diagnosis and treatment recommendations. Subsequent appointments are scheduled at a frequency determined to be appropriate to the clinical issues at hand. A commitment to regular follow-up appointments is essential in order to monitor clinical response to treatment and to optimize outcome.

#### **Late or Missed Appointments**

Each appointment is scheduled to begin and end on time. Please contact your clinician with at least 24 hours workday notice to cancel an appointment or the full. Please keep in mind that missed appointments disrupt your progress in treatment.

#### **Phone Calls**

Non-urgent clinical issues should be discussed at appointments. Telephone calls to your clinician should only be made for urgent matters that cannot wait until the next appointment. Please do not email or text about clinical matters,

#### **Medications and Refills**

Inform all of your doctors about all of your medications and any new medical problems. Prescriptions are not called in lieu of an appointment. Prescription refills are given at regular appointments. Requests for prescription refills by telephone will be granted only for patients being seen regularly.

#### **Privacy Notice**

By accepting services from Family Service Bureau of Newark, you are agreeing to the HIPAA NOTICE OF PRIVACY PRACTICES.

#### **HIPAA Notice of Privacy Practices – Effective Date: March 23, 2020**

This notice describes how health / medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact Family Service Bureau of Newark.

This notice describes the privacy practices at our office.

We are required by law to:

- Maintain the privacy of protected health information.
- Give you this notice of our legal duties and privacy practices regarding your health information.
- Follow the terms of the notice currently in effect.



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### **How Family Service Bureau of Newark, may Use and Disclose your Health Information**

Described as follows are the ways we may use and disclose your health information. Except for the following purposes we will use and disclose your health information only with your written permission. You may revoke such permission at any time by writing to Family Service Bureau of Newark.

#### **Treatment**

Family Service Bureau of Newark, may use and disclose your health information for your treatment and to provide you with treatment-related health care services. For example, we may disclose your health information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your health / medical care and need the information to provide you with health /medical care.

#### **Payment**

Family Service Bureau of Newark, may use and disclose your health information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give information to your health plan so that they will pay for your treatment.

#### **Health Care Operations**

Family Service Bureau of Newark, may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operation activities.

#### **Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services**

Family Service Bureau of Newark, may use and disclose your health information to contact you and remind you of your appointment, to tell you about treatment alternatives or health-related benefits and services you could use.

**Individuals Involved in Your Care or Payment for Your Care.** When appropriate, we may share your health information with a person involved in, or paying for, your care (such as your family or a close friend). Family Service Bureau of Newark, may notify your family about your location or condition or disclose such information to an entity assisting in disaster relief.

#### **Research**

Family Service Bureau of Newark, may use and disclose your health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we do so, the project needs to go through a special approval process. Even without special approval, we may permit researchers to look at records to help identify patients who may be included in their research, as long as they do not remove or copy any of your health information.

As required by Law, Family Service Bureau of Newark, will disclose your health information when required to do so by international, federal, state or local law.



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### **To Avert a Serious Threat to Health or Safety**

Family Service Bureau of Newark, may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public.

Disclosures will be made only to someone who can prevent the threat.

### **Business Associates**

Family Service Bureau of Newark, may disclose your health information to our business associates that perform functions on our behalf or provide us with services if necessary. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose the information for any other purpose than appears in their contract with us.

### **Military and Veterans**

If you are a member of the armed forces, Family Service Bureau of Newark, may release your health information as required by military command authorities. If you are a member of a foreign military, Family Service Bureau of Newark, may release your health information to the foreign military command authority.

### **Worker's Compensation**

Family Service Bureau of Newark, may release your health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

### **Public Health Risks**

Family Service Bureau of Newark, may disclose your health information for public health activities to prevent or control disease, injury or disability. Family Service Bureau of Newark, may use your health information in reporting births or deaths, suspected child abuse or neglect, medication reactions or product malfunctions or injuries, and product recall notifications. We may use your health information to notify someone who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. If we are concerned that a patient may have been a victim of abuse, neglect, or domestic violence we may ask your permission to make a disclosure to an appropriate government authority. Family Service Bureau of Newark, will make that disclosure only when you agree or when required or authorized to do so by law.

### **Health Oversight Activities**

Family Service Bureau of Newark, may disclose your health information to a health oversight agency for activities authorized by law. These may include audits, investigations, inspections, and licensure. These activities are necessary to for the government to monitor the health care system, government programs, and compliance with civil rights laws.

### **Lawsuits and Disputes**

If you are involved in a lawsuit or dispute, we may disclose your health information in response to a court or administrative order. Family Service Bureau of Newark, may disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.



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### **Law Enforcement**

Family Service Bureau of Newark, may release your health information request by law enforcement official if 1) there is a court order, subpoena, warrant, summons or similar process; 2) if the request is limited to information needed to identify or locate a suspect, fugitive, material witness, or missing person; 3) the information is about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain your agreement; 4) the information is about a death that may be the result of criminal conduct; 5) the information is relevant to criminal conduct on our premises; and 6) it is needed in an emergency to report a crime, the location of a crime or victims, or the identity, description, or location of the person who may have committed the crime.

Coroners, Medical Examiners, and Funeral Directors: Family Service Bureau of Newark, may release your health information to a coroner, medical examiner, or funeral director to identify a deceased person or cause of death, or other similar circumstance.

National Security and Intelligence Activities: We may disclose your health information to authorized federal officials for intelligence and other national security activities authorized by law.

Inmates or Individuals in Custody: If you are an inmate of a correctional institution or in custody, we may disclose your information 1) for the institution to provide you with health care, 2) to protect your health and safety or that of others, and 3) for the safety and security of the institution.

### **Your Rights Regarding Your Health Information**

#### **Right to Inspect and Copy**

You have the right to inspect and copy your medical and billing records by written request to Family Service Bureau of Newark.

#### **Right to Amend**

You have the right to request an amendment to your records by written request to Family Service Bureau of Newark.

#### **Right to an Accounting of Disclosures**

You have a right to an accounting of certain disclosures by written request to Family Service Bureau of Newark.

#### **Right to Request Restrictions**

You have the right to request restriction or limitation on your health information used for treatment, payment or health care operations. You may request Family Service Bureau of Newark to limit disclosure to someone involved in your care or in payment for your care (such as a spouse) by written request to Family Service Bureau of Newark. Family Service Bureau of Newark is not required to agree with your request, but we will try to comply.

#### **Right to Request Confidential Communication**

You have the right to request that Family Service Bureau of Newark, communicate with you about medical matters in a certain way or at a certain location. You can ask, for example, that we



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contact you only by mail or at work. Your written request must specify how or where you wish to be contacted and be addressed to Family Service Bureau of Newark, we will accommodate reasonable requests.

### Changes to this Notice

Family Service Bureau of Newark may change this notice and make it effective for medical information Family Service Bureau of Newark already has about you as well as new information. The current notice will be posted and available at all times. You have a right to request a paper copy of the current notice at any visit or by written request to Family Service Bureau of Newark.

1. Client Name: \_\_\_\_\_
2. Client Signature: \_\_\_\_\_
3. Address: \_\_\_\_\_
4. Date: \_\_\_\_\_



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### **Telehealth Contract and Informed Consent**

Introduction Sessions and visits will be held using video conferencing through a HIPAA compliant platform. Telehealth establishes a formal therapeutic relationship and maintains regular assessments, diagnostics, therapy, and/or prescription. Family Service Bureau of Newark, will be utilizing Health Insurance Portability and Accountability Act (HIPAA) protected software to ensure that your protected health information is secure from unauthorized access and that confidentiality is maintained. This document serves as a consent form for treatment via telehealth in general. In pages to follow are also our specific privacy practices.

- 1) You may elect to seek treatment in a more traditional, in-office visit with provider or another provider. Note that current evidence via rigorous studies has shown that treatment via telehealth is equivalent to face-to-face visits with a counselor / therapist / psychiatrist or Advanced Practice Nurse.
- 2) Pursuing treatment via telehealth is a decision made by you. If you choose to revoke your decision and pursue alternate treatment, you are able to withdraw your consent at any time. (Of course, we recommend discussing this decision with your provider first. Family Service Bureau of Newark also recommends establishing your next provider prior to termination to eliminate any gaps in treatment.
- 3) Unfortunate unpredictable consequences to telehealth can include but not limited to, disruption of transmission due to technology failure, interruption and / or breaches with confidentiality by unauthorized persons, and / or limited ability to respond to emergencies.
- 4) In the event that during a telehealth session there are technical difficulties resulting in service disruptions the provider and patient will reconnect via telephone for purposes of rescheduling.
- 5) There will be no recording of any online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and / or required by law.
- 6) It is understood that the privacy laws that protect the confidentiality of protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies. Such as, mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; or if mental / emotional or relapse issues are raised in legal proceedings.
- 7) If the patient is having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate and a higher level of care is required.
- 8) **Required Information at Every Visit:**  
Name, location, and telephone number of the patient at time of session. This is to ensure that our providers are aware of alternative means of treatment should an emergency occur.

In the event of imminent danger, the provider is legally and ethically bound to report information to authorities, family members, or others, to minimize potential harm. For



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this purpose, the client consents for a representative of Family Service Bureau of Newark to contact the following person in the event of an emergency:

Emergency Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

### 9) Cancellation and Late Policy:

Each appointment is scheduled to begin and end on time. Please contact your clinician with at least 24 hours workday notice to cancel an appointment. Please keep in mind that missed appointments disrupt your progress in treatment.

10) Consent: The patient understands that he/she is consenting to a behavioral health evaluation and/or substance use treatment via telehealth. The patient understands that no results can be guaranteed, despite our best efforts to deliver care. The patient understands that they are able to ask questions about telehealth or any aspects of the evaluation and treatment at any time.

☐ I certify that I have read and understand the entirety of this document, titled "Telehealth Contract and Informed Consent."

By signing below, I am agreeing with this document, put forward by Family Service Bureau of Newark and I am also authorizing Family Service Bureau of Newark to use telepsychiatry for my evaluation and treatment.

1. Client Name: \_\_\_\_\_

2. Client Signature: \_\_\_\_\_

3. Address: \_\_\_\_\_

4. Date: \_\_\_\_\_





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### **EMDR Agreement**

**Please sign each box after you have read the material.**

**Please note: E-Signing the form equates agreeing to each box.**

EMDR is a simple but efficient therapy using bilateral stimulation (BLS) — tapping, auditory tones or eye movements — to accelerate the brain's capacity to process and heal a troubling memory. BLS, which occurs naturally during dream sleep, causes the two brain parts to work together to reintegrate the memory. Some clients experience relief or positive effects in just a few sessions. EMDR is effective in alleviating trauma-related symptoms, whether the traumatic event occurred many years ago or yesterday. It gives desired results —with little talking, without using drugs, and requires no “homework” between sessions. \_\_\_\_\_(INITIAL)

Scientific research has established EMDR as effective for the treatment of post-traumatic stress, phobias, panic attacks, anxiety disorders, stress, sexual and physical abuse, disturbing memories, complicated grief and addictions. \_\_\_\_\_(INITIAL)

The possible benefits of EMDR treatment include the following:

- The memory is remembered but the painful emotions and physical sensations and the disturbing images and thoughts are no longer present.
- EMDR helps the brain reintegrate the memory and store it in a more appropriate place in the brain. The client’s own brain reintegrates the memory and does the healing.

\_\_\_\_\_(INITIAL)

The possible risks of EMDR treatment include the following:

- Reprocessing a memory may bring up associated memories. This normal and those memories will also be reprocessed.
- During the EMDR, the client may experience physical sensations and retrieve images, emotions and sounds associated with the memory. Reprocessing of the memory normally continues after the end of the formal therapy session.
- Other memories, flashbacks, feelings and sensations may occur. The client may have dreams associated with the memory. Frequently the brain is able to process these additional memories without help, but arrangements for assistance will be made in a timely manner if the client is unable to cope. \_\_\_\_\_(INITIAL)





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As with any other therapeutic approach, reprocessing traumatic memories can be uncomfortable; that means, some people won't like or be able to tolerate EMDR treatment well. Others need more preparation, offered by the therapist, before processing traumatic events using EMDR.

- There are no known adverse effects of interrupting EMDR therapy; therefore, a client can discontinue treatment at any time.
- Alternative therapeutic approaches may include individual or group therapy, medication, or a different psychotherapy modality.
- EMDR treatment is facilitated by a licensed psychotherapist having EMDRIA-approved training. \_\_\_\_\_(INITIAL)

### **HISTORY AND SAFETY FACTORS**

The client must:

- Be willing to tell the therapist the truth about what he/she is experiencing. \_\_\_\_\_(INITIAL)
- Be able to tolerate high levels of emotional disturbance, have the ability to reprocess associated memories resulting from EMDR therapy, and to use self-control and relaxation techniques (e.g. calm place exercise). \_\_\_\_\_(INITIAL)
- Remember debriefing instructions and call his/her therapist, connect with supportive family or friends, or use meditation or other techniques (e.g. calm place exercise) he/she has agreed to in therapy, if needed. \_\_\_\_\_(INITIAL)
- Disclose to therapist and consult with his/her physician before EMDR therapy if he/she has a history of or current eye problems, a diagnosed heart disease, elevated blood pressure, or is at risk for or has a history of stroke, heart attack, seizure, or other limiting medical conditions that may put him/her at medical risk. Due to stress related to reprocessing traumatic events, pregnant women should consider postponing EMDR therapy. \_\_\_\_\_(INITIAL)
- Inform therapist if he/she is wearing contact lenses and will remove them if they impede eye movements due to irritation or eye dryness. The therapist will discontinue bilateral stimulation (BLS) eye movements if client reports eye pain and use other dual stimulation (tapping, sounds) to continue reprocessing. \_\_\_\_\_(INITIAL)
- Assess his/her current life situation to determine EMDR approach. Client may need the ability to postpone demanding work schedule immediately following EMDR session. \_\_\_\_\_(INITIAL)



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- Before participating in EMDR, discuss with therapist all aspects of an upcoming legal court case where testimony is required. The client may need to postpone EMDR treatment if she/he is a victim or witness to a crime that is being prosecuted because the traumatic material processed using EMDR may fade, blur or disappear and her/his testimony may be challenged.

\_\_\_\_\_(INITIAL)

- Understand disagreements with family and/or friends may occur as she/he learns new skills such as assertiveness or social skills after processing problems and disturbing material using EMDR. Vulnerable clients may need to be protected. \_\_\_\_\_(INITIAL)

- Be willing to explore the issues(s) that may arise as change occurs. For example, changes regarding your identity; finances; loss of identification with a peer group; and/or attention.

\_\_\_\_\_(INITIAL)

- Consult with his/her medical doctor, before utilizing medication. Some medications may reduce the effectiveness of EMDR. For example, benzodiazepines may reduce effectiveness possibly due to state-dependent processing and/or regression may occur after ceasing anti-depressants. \_\_\_\_\_(INITIAL)

- Address with the therapist his/her ability to attend to EMDR due to recent cocaine dependence, long term amphetamine abuse, seizures, and/or other neurological conditions. EMDR is contraindicated with recent crack cocaine users and long-term amphetamine users.

\_\_\_\_\_(INITIAL)

- Discuss with the therapist any Dissociative Disorders; Dissociative Identity Disorder unexplained somatic symptoms, sleep problems, flashbacks, derealization and/or depersonalization, hears voices, unexplained feelings, memory lapses, multiple psychiatric hospitalizations, multiple diagnoses with little treatment progress - EMDR may trigger these symptoms. \_\_\_\_\_(INITIAL)

Client Name: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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### **Insurance Billing Form**

I, \_\_\_\_\_, give permission to the Family Service Bureau of Newark to  
Client Name (Print)  
bill:

- ☐ Self-Pay
- ☐ DCPD
- ☐ Drug Court (DCI)
- ☐ FCIU
- ☐ Harmony House
- ☐ Medicaid
- ☐ Medicare
- ☐ NJMHAPP
- ☐ Other funding
- ☐ Parole (SPB)
- ☐ Private Insurance (Aetna, Horizon BCBS)
- ☐ SAI/BHI
- ☐ VCCO

By my signature below, I hereby authorize assignment of financial benefits directly to Family Service Bureau of Newark. I understand that I am financially responsible for charges not covered by this assignment.

\_\_\_\_\_  
Client Name

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Parent/Legal Guardian's Name

\_\_\_\_\_  
Parent/Legal Guardian's Signature

\_\_\_\_\_  
Date



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### **Financial Attestation Letter**

Re:

\_\_\_\_\_

This letter is a written declaration regarding the above-named individual's financial status.

**Please check the one condition that best describes your financial status.**

☐ I am currently employed by \_\_\_\_\_ (company's name) and getting paid \_\_\_\_\_ (gross work income per pay period) weekly/ bi-weekly/ monthly (please circle one payment period). The payment is cash; thus, I am not able to provide any proof income.

☐ I am currently unemployed and \_\_\_\_\_ (supporter's name) is providing financial assistance (housing/rent/food) for me during the time of my unemployment.

☐ I am currently unemployed and do not have any income source.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date



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### **Client Financial Responsibility**

Positive verification of your coverage cannot always be made at the time of service. You will receive services with the understanding that in the event your coverage is not effective, you will be billed and held financially responsible for the services rendered. Payment is due before your next scheduled appointment or by the last day of the month, whichever date comes first. Failure to pay for services rendered will result in the agency discontinuing services, referring you to another facility, and closing your case.

If you are self-pay, your payment is due before the start of your session. Failure to pay for services rendered will result in the agency discontinuing services, referring you to another facility, and closing your case.

If, after your insurance is billed, should your policy apply any additional amount to your out-of-pocket expense, you are personally responsible for that amount and will be billed for that balance then due.

Payment is accepted via cash, credit/debit card, or PayPal.

I have read the above and understand my possible financial responsibility of services rendered and my signature below represents my acknowledgment of this understanding.

---

Client Name

---

Client Signature

---

Date

---

Staff Name

---

Staff Signature

---

Date

## Family Service Bureau of Newark

### Outpatient Service

Persons in Family	Federal Poverty Level	250% (Outpatient)			300%			350%			Above 350%
	If BELOW this amount	If BETWEEN this			If BETWEEN this			If BETWEEN this			AT OR ABOVE
	\$35 Outpatient	\$50 OP weekly fee			\$65 OP weekly fee			\$80 OP weekly fee			\$95 OP weekly fee
	\$70 IOP weekly fee	\$105 IOP weekly fee			\$140 IOP weekly fee			\$175 IOP weekly fee			\$200 IOP weekly fee
	Use funding monies only (if available)	Not eligible for funding Self-Pay Only			Not eligible for funding Self-Pay Only			Not eligible for funding Self-Pay Only			Not eligible for funding Self-Pay Only
1	\$12,760	\$12,760	to	\$31,900	\$31,900	to	\$38,280	\$38,280	to	\$44,660	\$44,660
2	\$17,240	\$17,240	to	\$43,100	\$43,100	to	\$51,720	\$51,720	to	\$60,340	\$60,340
3	\$21,720	\$21,720	to	\$54,300	\$54,300	to	\$65,160	\$65,160	to	\$76,020	\$76,020
4	\$26,200	\$26,200	to	\$65,500	\$65,500	to	\$78,600	\$78,600	to	\$91,700	\$91,700
5	\$30,680	\$30,680	to	\$76,700	\$76,700	to	\$92,040	\$92,040	to	\$107,380	\$107,380
6	\$35,160	\$35,160	to	\$87,900	\$87,900	to	\$105,480	\$105,480	to	\$123,060	\$123,060
7	\$39,640	\$39,640	to	\$99,100	\$99,100	to	\$118,920	\$118,920	to	\$138,740	\$138,740
8	\$44,120	\$44,120	to	\$110,300	\$110,300	to	\$132,360	\$132,360	to	\$154,420	\$154,420
For each addtl person, add	4480										

Intake/ Assessment	\$100	
Anger Management Group	\$180	6 Groups
Parenting Group	\$240	8 Groups
Initial Psychiatric Evaluation	\$130	
Yearly Psychiatric Evaluation	\$130	
Medication Management	\$75	
Urine Screening	\$50	
Urine Screening with EtG	\$75	