Welcome to the office. I hope your visits here will be helpful. A clear understanding of the role of a psychologist and of my office policies will help that be true. Please read what follows carefully because it will help you use my services effectively. Then ask me any questions that you may have.

WHAT IS A LICENSED, BOARD CERTIFIED PSYCHOLOGIST?

Licensed psychologists provide two basic services: 1. Helping people resolve personal, family, and work problems; 2. Providing psychological testing to help them understand people and their problems.

In New York, those allowed by law to use the title Licensed Psychologist have learned a Ph.D. degree from a graduate school approved by the New York State Professional Licensing Board and the Board of Regents. After the doctorate and an internship, they also have two years of supervised experience prior to licensure. They may also have postgraduate training beyond the license and frequently attend continuing education to keep their skills current. Psychologists are trained in a broad range of problem solving strategies, psychological testing and in scientific research. Licensed psychologists who have been in practice for at least three years or more may seek specialty Board Certification. The American Board of Professional Psychology (ABPP) exam is the only test assessing competence and ethical practice of psychologists. The examination focuses on actual clinical skills and effectiveness, and is neither a credential review like the National Register nor a test of academic knowledge like the licensing exam.

After my Bachelors training in psychology and German at the State University College at Oneonta and two years of university training in psychology at the Universities of Wuerzburg and Bonn in Germany, I completed graduate training in psychology at SUNY at Buffalo earning a Masters and a Doctoral Degree. I taught psychology at the college level for five years. After being licensed in New York State, I had six years of specialized postdoctoral training in working with individuals, couples and families in psychotherapy. I have been working as a psychologist since 1977 and attend continuing education seminars and workshops. I am also Board Certified in Clinical Psychology from the American Board of Professional Psychology (ABPP). Board Certification recognizes, certifies and promotes advanced competence in the specialty of Clinical Psychology. ABPP board certification is the only board certification recognized by the 156,000-member American Psychological Association or the National Register of Psychologists. There are about 1300 licensed, board certified clinical psychologists nationwide.

The Nature of Therapy

Psychotherapy is not easily described in general statements. It varies depending on the particular problems the client brings and the personality of both the client and the therapist. There are several different approaches that can be used to address problems. Unlike visiting a medical doctor, psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy has both benefits and risks. Therapy often leads to a significant reduction in symptoms of distress, better relationships, and resolutions of specific problems. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger and frustration, loneliness, and helplessness. Psychotherapy often requires discussing unpleasant aspects of your life.

During the first few sessions we will focus on an evaluation of your needs. I will then be able to offer you some initial impression of what our work will include and an initial treatment plan for you to follow. You should evaluate this information along with your own assessment about whether you feel comfortable working with me. At any time during the therapy process, you should feel free to raise any questions or concerns that may arise and you may, of course, discontinue treatment and/or ask for referrals.

OFFICE HOURS

Appointment dates and times are as scheduled. Appointments begin on the hour and are usually about an hour in length. Longer appointments or more frequent appointments can be arranged if needed.

CONFIDENTIALITY

The information you share with me is confidential. This office is HIPAA compliant. That means that information about you cannot leave the office without your permission. If you want me to share information with another professional or if you have seen another therapist and would like me to communicate with that professional, I will ask you to sign the form at the back of this packet of information giving the office permission to do so.
Exceptions:

1. As per New York State law, confidentiality may be breached in cases where on-going child abuse is evident. This law requires me to make a report to the Department of Social Services whenever I have reason to *suspect* child abuse. Your permission for such a report is not required.
2. If there is clear intention on your part to do serious harm to yourself or to someone else or to commit a crime, I will share that information appropriately in an attempt to prevent that harm from occurring
3. There have been instances in which therapy records have been subpoenaed to court. The most likely time for this to arise is in child custody battles. This strategy is almost never helpful to anyone, but some lawyers still advise it. There are circumstances under which I would be held in contempt of court if I do not provide my records and/or opinion for the court.
4. In cases of routine consultation with another licensed mental health professional.
5. If non-payment of fees requires the use of a collection agency (after 60 days).

The New York Safe Act as applies to Psychologists and Social Workers

If I become reasonably concerned that you might be likely to engage in conduct that would result in serious harm to yourself or others, I must conduct an assessment of whether you meet the reporting requirement under the SAFE Act in addition to notifying local authorities. If, as a result of this assessment, I determine that you are likely to engage in conduct that would result in serious harm to yourself or others, I am required to make a report to the Director of Community Services. If the Director of Community Services agrees with my assessment, he/she then reports ONLY your name and other non-clinical information to the New York State Department of Criminal Justice Services.

The New York State Department of Criminal Justice Services (DCJS) can then use this information ONLY to determine whether your firearms license should be suspended or revoked, or, if you do not have such a license, whether you will be ineligible for the issuance of a firearms license. This data must be removed from the DJCS database five years after the receipt of the name and non-clinical information.

As your therapist, I do everything possible to assure that your protected mental health information is not available to anyone without proper authorization. Should there be any breaches of your protected mental health information, you will obviously be notified immediately. Such breaches include unauthorized access to your protected mental health information and also impermissible uses by knowledgeable insiders. HIPAA compliance is assured through any business associate contracts with any employees working for me (e.g., billing personnel).

The internet and social media present other challenges to confidentiality. See my **Policy on Internet and Social Media** for more information about how I manage this.

VISITS AND FEES

Consultation and therapy visits usually last about an hour. The private pay fee is $200 per hour. Group therapy is $65 for a 90-minute session. Psychological testing fees are variable are will be discussed with you if testing is recommended. Special services, such as school visits and court appearances, are billed at the hourly rate, including travel time. Special documentation requests that cannot be completed in session will be billed at the hourly rate. Insurance reimbursement rates vary depending on the service and the company.

Fees are due at time of service. Payment can be made with cash, check, and all major credit cards and Paypal. All checks should be made payable to Jonathan Treible, Ph.D. Statements showing dates of visits, charges, and payments can be provided upon request. The issue of insurance coverage has become quite complicated in these days of change. Information about benefits can always be provided by your incuracne company. Our office will do everything possible to inform you about your benefit as soon as we can.

COMMUNICATION WITH THE OFFICE

Emergency or extra appointments can be made during regular office hours. If need be, office hours will be extended to accommodate this need. However, in order to be fully rested for my regular office hours and in order to maintain my own family life, I am not available for after-hours emergencies. In the unlikely event that such services are required, please call the local crisis hotline (Crisis Services: 716-834-3131) or go to the nearest hospital emergency room.

If you call 716-480-1997 on weekday late afternoons your phone call may be answered personally. We use voice mail in the office when I am in session and we cannot answer the phone. You may leave messages for me on voicemail or text. Calls/messages will be returned as soon as possible throughout the day. Some people do not like to use voicemail or send a text. We have found “live” answering services to be equally frustrating at times so we continue to use voicemail and text.

CANCELLATION POLICY

Since appointment times are reserved solely for you, early cancellation is imperative. Cancellations must be made 48 hours in advance to avoid a charge to your account. There are several reasons why this policy is strictly followed: 1. Regular appointments are necessary for therapy to work. 2. Frequently, others would like to use the time set aside for you should it become available. Forty-eight hours usually gives people sufficient time to make arrangements. 3. Since therapy visits run about an hour, each appointment constitutes a significant portion of my schedule. Losses from missed appointments are not easily absorbed and lead to more rapid fee increases. . Fees for sessions that you do not attend and do not cancel within the specified time are not covered by your insurance policy. You are solely responsible for these charges.

Exceptions: When an illness leads to a visit to your doctor's office or a hospital, or when the weather is severe enough to close the public schools in your area, I will not charge for a missed appointment.

Office Policies
SUMMARY

CLIENT RIGHTS:

1. To confidentiality except: a) when your safety or the safety of others is in question. b) in routine consultation with a licensed mental health professional. c) if non-payment of fees requires use of a collection agency.
2. To participate in treatment plan formulation and review.
3. To referral to collateral treatment, for example group therapy
4. To regular review of progress and to a summary of progress at the closure of therapy.

CLIENT RESPONSIBILITES:

1. To arrive for scheduled appointments on time, rested, and ready to participate.
2. To call with two business days' notice to rearrange or cancel appointments.
3. To pay fees promptly at time of service.
4. To discuss any dissatisfaction with your therapist about services received.

I have read and understand all of the above information.

_____ _____
Signature Date

_____ _____
Signature Date

RELEASE OF INFORMATION

MANAGED CARE*

As a participant in a managed care plan, I recognize that Dr. Treible, in the course of my treatment and after treatment, may need to release to managed care representatives:

1. Written and phone reports including impressions, mental status, diagnosis, symptoms, stressors, treatment plan, response to treatment, recommendations and psychological test reports.

2. Copies of protected health information or physical review of chart.

This material/information may be released in order to obtain approval of further sessions with Dr. Treible or may be released for review after my treatment has ended.

I agree to release of this information as per above conditions.

Signature_____

Date_____

Witness_____

I hereby refuse to release the aforementioned information for myself (or my child). I restrict release of information to diagnosis, treatment, case circumstances, telephone calls, and completion of managed care forms. I am aware that such refusal may effect reimbursement for treatment.

Signature_____

Date_____

Witness_____

***Most plans are not managed as of this writing.** If unsure, ask us if your plan is managed. This will be explained to you during initial visits. You can always ask your insurance company directly about your benefit and the limits of confidentiality as well.

CLIENT INFORMATION

Today's date: _____ MOBIL PHONE_____

NAME: _____DOB: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

E-MAIL_____

EMPLOYER: _____
WORK PHONE _____

FULL TIME PART TIME FT STUDENT PT STUDENT OTHER

SOCIAL SECURITY NUMBER (SSN):
_____

MARITAL STATUS: Single Divorced Separated Widowed Married Live with

Significant other/Spouse's Name: _____ DOB: _____

OCCUPATION: _____EMPLOYER: _____

Significant other's/Spouse's SSN: _____ WORK PHONE: _____

NUMBER OF CHILDREN IN THE FAMILY: _____

MY PRIMARY CARE PHYSICIAN (PCP) IS:
_____

ADDRESS OF PHYSICIAN:
_____

CITY AND ZIP CODE: _____ PCP's PHONE:
_____

You have my permission to coordinate my mental health treatment with my physician and may update him/her regularly regarding the status of my condition. I understand I my revoke this permission at any time in writing and that protected health information will be released. This release is renewable yearly from the date below.

Signature: _____

Date: _____

Rev.: 8-2022

FINANCIAL / INSURANCE INFORMATION

WHO IS REPONSIBLE FOR THIS ACCOUNT? _____

NAME OF PRIMARY INSURANCE COMPANY: _____

SUBSCRIBER/INSURED'S NAME: _____DOB: _____

WORK

SUBSCRIBER EMPLOYED AT: _____ PHONE: _____

SUBSCRIBER'S ADDRESS AND PHONE # IS DIFFERENT FROM PATIENT'S:

ADDRESS: _____

CITY, STATE, ZIP: _____PHONE: _____

RELATIONSHIP OF PATIENT TO THE PERSON INSURED: _____Self ____Spouse ____Child ___Other

INSURANCE ID #: _____ GROUP #: _____

ARE YOU COVERED BY MEDICARE? _____YES ____NO

DOES THE PATIENT HAVE OTHER INSURANCE COVERAGE: ____YES ___NO

IF YES, PLEASE PROVIDE THE FOLLOWING:

2ND INSURANCE COMPANY NAME: _____

SUBSCRIBER'S/INSURED'S NAME: _____DOB: _____

WORK

SUBSCRIBER EMPLOYED AT: _____ PHONE: _____

SUBSCRIBER'S ADDRESS AND PHONE # IF DIFFERENT FROM PATIENT'S:

ADDRESS: _____

CITY, STATE, ZIP: _____PHONE: _____

RELATIONSHIP OF PATIENT TO THE PERSON INSURED: _____ Self _____Spouse
_____Child _____ Other

Insurance ID #: _____ Group #: _____

Major credit card Payment. I authorize Dr. Treible to charge my credit card for unpaid balances.

Card Number: _____

Three Digit Identifier (Back of Card): (AMEX 4 digit front of card)_____

Expiration Date: _____

Signed: _____ Date: _____
Please have credit card available for copying.

FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. *ANY MISSED APPOINTMENTS NOT CANCELLED AT LEAST 48 HOURS PRIOR TO THE SCHEDULED TIME MAY BE BILLED AT THE EXPECTED RATE FOR THAT APPOINTMENT . OUTSTANDING CHARGES INCLUDING MISSED APPOINTMENT FEES MAY BE CHARGED TO MY CREDIT CARD.*

I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION OBTAINED DURING ASSESSMENT OR TREATMENT WHICH IS NECESSARY TO EXPEDITE AND SUPPORT ANY INSURANCE CLAIMS ON THIS ACCOUNT. *I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES, REGARDLESS OF INSURANCE COVERAGE.*

SIGNATURE: _____ DATE: _____

Rev: 8-2022

Authorization to Release Protected Health Information (PHI)

I authorize Jonathan Treible, Ph.D. to *release to / receive from* (circle one)

_____

_____

Protected Health Information (PHI) about my sessions, including the times, dates, and types of psychotherapy sessions; summaries of my symptoms, diagnosis, and treatment plan; and summaries of my prognosis and progress to date. This does not include the therapist's notes on my sessions. This information may be*: released to / received from* (circle one):

_____

_____

(name and address of person the information is to be: *released to / received from* {circle one})

This information is being released for the following reasons:

_____

("at the request of the individual" is all that is required if you do not desire to state a specific purpose)

This authorization shall remain in effect for one year.

Client Rights: You have a right to inspect the contents of your client file and the information released, and if you disagree with the file contents, to submit an Amendment to your records.

Revocation of Consent: You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address with both your signature and that of a witness. However, your revocation will not impact information already released, or release of some information to insurance companies with the legal right to this information.

Conditioning of Services: Your psychologist generally may not condition psychological services upon your signing an authorization, although you may then have to pay for services without the aid of any insurance benefits.

The APA Code of Ethics (2002), HIPAA regulations as well as other applicable state and federal laws govern this Authorization.

_____ _____

Signature of Patient Witness

_____

Date