Brighter Living, LLC

47 Reckless Place
Red Bank, NJ 07701
(732) 219-9002
Tax ID #02-0777-007
WWW.THERAPYREDBANK.COM

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Patient Information

Print Patient Name:_____ DOB:_____

Mailing Address: _____

City/Town:_____State:_____Zip Code: _____

Marital Status: _____ Sex:_____ Age:_____ Telephone:_____

Parent/Guardian Information

Print Full Name: _____ DOB:_____

Email:_____SS#:_____

Marital Status:_____ Sex:_____ Age:_____ Telephone:_____

Work Phone:_____ Cell Phone:_____

In Case of Emergency Phone: _____

Who Referred You:_____
Phone: _____

Do I have permission to speak to your referral source regarding your care if need be? Y / N (circle one)

I hereby consent for _____ to be seen by the affiliates of Brighter Living, LLC. I understand that they are out of network providers, and that I am financially responsible for all appointments to be paid in full at the time of the session regardless of reimbursement from my insurance company. There will be a returned check fee of $30. I MUST sign a release of information form for this patient's information to be shared verbally, by fax, or by mail with anyone. A release form is available upon request. Your privacy is our number one priority. All appointments must be canceled within 24 hours notice prior to the scheduled appointment, otherwise a charge will be implemented for my missed session, which cannot be submitted to my insurance for reimbursement.

Parent Signature:_____Date: _____

Patient Signature:_____ Date: _____

Office Policies

Compliance with appointments is the key to successful psychotherapy sessions. If you fail to show for your appointment, or you cancel without 24 hours notice, you will be charged for your session in full. This fee will be payable by you and cannot be processed through your insurance company. Exceptions may be made on a case-by-case basis if a sudden illness or inclement weather arises, preventing you from coming to your appointment. If you reschedule your appointment within the same week, the cancellation fee may be waived at the discretion of the provider.

We do not accept insurances; therefore we are considered out of network providers. Payment is due in full at the time of each session. You will receive a receipt to submit to your insurance company, should you have out of network benefits and may be able to be reimbursed. **The cost of 45 minute appointments are $195 per session and 60 minute appointments are $250 per session (with an additional 3% fee for credit card transactions).** It is your sole responsibility to know your insurance benefits as we cannot guarantee that they will reimburse you, and at what rate. A $30 return check fee will be assessed for any checks that are returned by your bank.

Communication Policy

Please note that our office uses text messaging only to schedule or confirm appointments. Text messaging should not be used to communicate clinical questions or concerns to our clinicians. Clinicians may be in session or outside office hours and are not available for emergencies. If you are experiencing an urgent medical situation, please contact your nearest emergency room or dial 911. If you feel you may be at risk of harming yourself or others, seek immediate emergency assistance.

All sessions are considered completely confidential unless you give written permission. If you are at risk of hurting yourself or others, we are obligated by law to take reasonable precautions to ensure safety. Courts may also subpoena treatment records.

As of January 2022, you have the right to receive a "Good Faith Estimate" explaining how much your mental health care will cost. Under the new law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the expected charges for medical services, including psychotherapy services. You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services, including psychotherapy services. You can ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service.

I have read and agree to all of the above statements regarding the office policies/procedures at Brighter Living, LLC.

Patient Name: _____ **DOB:** _____

Signature: _____ **Date:** _____

Printed Name: _____

Relationship to Patient: _____

Release of Information

Date:_____

Client Name: _____ DOB:_____

I hereby consent for information regarding the treatment and progress of the above client to be shared by any affiliate of Brighter Living, LLC to the parties listed below. All information shared is considered confidential. Therefore, parent and client permission is mandatory. This release of information form has no expiration date unless otherwise noted. You must give a written retraction of the right to share your information should you decide you no longer wish our affiliates to speak to the parties listed regarding your care. Your privacy is our number one priority.

The affiliates of Brighter Living, LLC have permission to speak to the following parties regarding my care:

Name : _____ Name: _____

Address : _____ Address : _____

City : _____ City : _____

State : _____ Zip : _____ State : _____ Zip : _____

Phone : _____ Phone : _____

Fax : _____ Fax : _____

Parent Signature : _____ Date : _____

Client : _____ Date : _____

Credit Card Form

Brighter Living, LLC
47 Reckless Place
Red Bank, NJ 07701

I, _____ understand that my credit card listed below will be charged a non-refundable fee of $195 in the event that I do not show for a scheduled appointment, do not inform my therapist of my need to cancel/reschedule my appointment at least 24 hours before my scheduled appointment time, OR in the case of non-payment due to a bounced check. Further, I understand that there is a $30 fee for bounced checks.

I understand Brighter Living, LLC's fee schedule below and that I will be charged a 3% fee on top of these fees to use a credit card. I also understand any time with my therapist outside of a session resulting in a conversation longer than 10 minutes will be charged accordingly. Phone conversations can be scheduled to address issues outside of session time.

Any preparation of written documentation, letters, or other correspondence outside of scheduled sessions will be billed a fee of $75.

Session Fees	**Conversation Fees**
30 Minutes - $150	**15 Minutes - $50**
45 Minutes - $195	**30 Minutes - $100**
60 Minutes - $250	**45 Minutes - $150**
90 Minutes - $350	**60 Minutes - $200**

The following signature authorizes Brighter Living, LLC to both keep my credit card information on file for services rendered, as well as charge my credit card in the case of aforementioned circumstances.

_____
Print Name (Cardholder)

_____
Signature (Cardholder)

_____
Date

Please be sure to notify Brighter Living, LLC of any changes to this information.
Credit Card Number: _____
Security Code: _____
Expiration Date: (MM/YY) _____
Billing Zip Code: _____

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Notice of Policies and Practices to Protect the Privacy of Your Health Information (HIPAA Form)

Experience has taught us that it is easier to focus on the process of therapy when all expectations and ground rules are clearly understood.
Therefore, please read through the following policies and procedures. If you have any questions or concerns, please discuss them with your therapist before signing this agreement. Your signature indicates your agreement with all aspects of the following:

1. **Confidentiality:** We will not release or transfer any information pertaining to you without your express written consent. The only exceptions are required by law (Duty to Protect Bill, signed 8/27/91) as follows:
    - **a. Serious Threat to Health or Safety:** When an individual's thoughts or actions pose a threat to her/himself, we must report this suicidal intent to the immediate family, the police, or arrange for you to be admitted to a psychiatric unit of a hospital or other healthcare facility. When and individual's thoughts or actions pose a threat to another, we must report this homicidal intent to the target or to the police.
    - **b. Child Abuse:** When we have reasonable cause to believe that child abuse or neglect has occurred, or is occurring, we must take a report to DCP&P (formerly known as DYFS).
    - **c. Adult or Domestic Abuse:** If we reasonably believe that a vulnerable adult is the subject of abuse, neglect, or exploitation, we may report the information to the county adult protective services provider.
    - **d. Health Oversight:** If the New Jersey State Board of Psychological Examiners issues a subpoena, we may be compelled to testify before the Board and produce your relevant records and papers.
    - **e. Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that we have provided you and/or the records thereof, such information is privileged under state law, and we must **NOT** release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. We must inform you in advance if this is the case.
2. **Cancellation Policy:** Appointments must be canceled or rescheduled by phone or text at least 24 hours in advance, unless there is a serious emergency, or you will be responsible to pay your full session fee of $195.
3. **Length of Session:** Individual sessions are approximately 45 minutes in length. There are times when a longer session is needed. Extended session length and fees

need to be discussed prior to lengthening session.

4. **Payment Policy:** Payment is due in the form of cash, check, or credit card at the beginning of each session. We do not accept insurance and it is the responsibility of the client to determine what out of network benefits your insurance company offers. It is also the responsibility of the client to submit all necessary documentation to the insurance company in order to retain reimbursement. A receipt will be provided for proof of payment, which also serves as the invoice needed for the purpose of submission to the insurance company for reimbursement.

5. **Billing:** If you need a bill for your records or insurance company, one will be prepared for you.

6. **Uses and Disclosures Requiring Authorization:** We may use or disclose your protected health information (PHI) for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment, and health care operations, we will obtain an authorization from you before releasing this information.

7. **Lateness:** If you are late, your session will still end as scheduled. This may occur because there is a client directly scheduled after you. Please notify your therapist by calling or sending a text message if you anticipate that you will be late. If you are more than 15 minutes late, it may not be clinically appropriate to hold the session and you may be asked to reschedule.

Print Name: _____

Signature of Acknowledgement: _____

Date: _____