

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

**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 an 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 \$185.

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 and 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: _____