Ilana S. Rosenberg, Ph.D.
Clinical Psychologist, NJ License # 4447
70 East Allendale Rd
Saddle River, NJ 07458
(201) 921-3560

INFORMED CONSENT TO RECEIVE PSYCHOTHERAPY SERVICES

The following is a description of the services offered by Dr. Ilana Rosenberg, a New Jersey licensed psychologist:

Our first few sessions will involve an evaluation of your needs, and a review of relevant information is obtained. By the end of the evaluation, I will be able to offer you some impressions of what your problems are and exactly what our work will include.

Sessions typically involve one weekly face-to-face 45-minute session with an individual, couple, or family. Psychotherapy may also include emergency sessions, phone sessions, e-mail, or consultation with other providers. Any changes to the frequency, intensity, or duration of therapy are discussed with patients as part of ongoing treatment planning. Once we schedule your appointment time, it will not be available to other patients. Thus, if any scheduling changes become necessary, these must be made **by mutual agreement at LEAST 24 BUSINESS HOURS PRIOR** to our next scheduled appointment. If you cancel an appointment you are responsible for and agree to pay the full session fee (no later than the next scheduled appointment) unless other arrangements are made.

Potential Benefits of Psychotherapy

Therapy requires a comfortable working relationship between us. In order for therapy to be successful, you will have to work on the issues we talk about during our sessions and at home. Since therapy involves discussing unpleasant aspects of your life, the experience can lead to personal discomfort and may bring up uncomfortable feelings like sadness, frustration, and anger. Psychotherapy often benefits people by leading to better relationships and solutions to specific problems. Psychotherapy may help a person understand the nature of their problems more clearly and prepare them for future treatment services. Psychotherapy may alleviate psychological distress by providing patients with treatment that increases clarity about oneself and/or others, improves interpersonal communication skills, and fosters increased self-acceptance and/or acceptance of others.

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Potential Risks of Psychotherapy Services
Consultations may fail to provide clear answers to the questions that the patient would like answered. The individual or parent/guardian may experience distress at the treatment recommendations and/or the results of the consultation. Psychotherapy Services may fail to achieve the desired result such as to decrease distress, improve relationships, change negative behaviors, or enhance self-awareness.

Alternative Treatments
Anyone considering receiving services has the right to an explanation of all treatment modalities and the potential risks, benefits, costs, and expected time frame of treatment. All patients have the right to choose treatment, stop treatment, or seek treatment from another provider. The Psychotherapy Services offered by Dr. Rosenberg are done so on a voluntary, fee-for-service basis. If you have any questions about my procedures, please discuss them whenever they arise. If your concerns persist, I will be happy to help you arrange a consultation with a mental health professional for a second opinion.

Professional Records
I am required to keep treatment records, including session notes, by law and these as well as any other communication between us will remain confidential. Records, including those sent to an insurance company, are released only by your consent. The exceptions to this would be court order, or mandated report to DYFCS/appropriate agency if abuse/neglect is suspected. I also have a legal obligation to contact the appropriate agency or person if there is possible intent to harm yourself or others. Should any such contact become necessary, I will make every effort to discuss this with you before any action is taken.

I am required to keep all clinical information pertaining to a client confidential. On occasion, I may find it helpful to consult with another licensed professional. I avoid revealing the identity of the client, and the consultant is legally bound to keep the clinical information confidential as well.

Phone Contact/Emergencies
I can be reached at the phone number listed above. This is a cell phone, and you may leave a message on my voice mail, which is accessed only by me. Routine calls are returned within 1-2 business days. If no call back is received within this time frame, please leave your message again. In any event, understand that in an extreme emergency you are to go immediately to your local emergency room and ask for the Psychiatrist on call, dial 911 for emergency assistance, or dial 201-262 HELP.

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Professional Fees

You are expected to pay for each session at the time it is held. I do not participate in any insurance plans, but I will give you a statement on a monthly basis (unless you request it to be at the time of session) so that you may obtain reimbursement from your insurance company. Please note that you are responsible for all charges resulting from returned checks. In the event of a missed session, without 24 hr cancellation, you will be charged your session fee.

Other charges may incur, such as reports to be written on your behalf or phone sessions lasting more than five minutes with yourself or with other parties relevant to your case. If there are such charges, they will be billed at the end of the month.

Fee Schedule

Initial Evaluation	**$ 250.00**
45-min Psychotherapy Session	**$ 200.00**
1-hr Psychotherapy Session	**$ 250.00**
1-hr Couples session	**$ 250.00**

I have read and understand this statement and agree to abide by its terms

_____ **Date**_____

If minor, please sign below:

_____ **Date**_____

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Phone: 201-921-3560
Email: Ilanarosenberg@mac.com
Website: www.ilanarosenbergphd.com

New Patient Registration Form

Full Name: _____

Address: _____
_____

Date Of Birth (age): _____

Married: ☐ YES ☐ No
Children: ☐ YES ☐ No
Names & Ages: _____

_____

Email: _____

Cell Phone: _____

Home Phone: _____

Reason for Visit: _____

_____

_____

Previous Psychotherapy: ☐ Yes ☐ No

When? _____

Was it beneficial? ☐ Yes ☐ No

Current Medications: _____
_____

Previous Medications: _____
_____

Referral Source: _____

HIPAA NOTICE OF PRIVACY NOTICES

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.*

This Notice of Privacy Practices describes how I may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present and future physical or mental health condition and related health services.

Uses and Disclosures of PHI: Your PHI may be used and disclosed by your physician, my office, and others outside my office that are involved in your care and treatment for the purpose of providing health care services to you, to pay our health care bills, to support the operation of the practice, and ant other use required by law.

Treatment: I will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of tour health care with a third part, for example, I would disclose your PHI, as necessary, to a home health agency that provides care for you. Your PHI may be provided to a physician to who you have been referred to ensure that the physician has the necessary information to diagnose you.

Payment: Your PHI will be used, as needed, to obtain payment for your mental health care services. For example, obtaining approval for continued sessions may require that your relevant PHI be disclosed to the health plan to obtain approval for the sessions.

Healthcare Operations: I may use or disclose, as needed, your PHI in order to support the business activities of this practice. These activities include, but are not limited to, quality assessment activities, licensing and conducting or arranging for other business activities. For example, I may call you by name in the waiting room when I am ready to see you. I may use PHI, as necessary, to contact you and remind you of your appointment.

I may use or disclose your PHI in the following situation without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases; Abuse and Neglect (DYFS, Adult Protected Services); Food and Drug Administration requirements; Legal Proceedings; Criminal Activity; Workers Compensation.

Other Permitted and Required Uses and Disclosures will be made ONLY WITH YOUR CONSENT, ATHORIZATION OR OPPORTUNITY TO OBJECT unless required by law.

You may revoke this authorization/notice, at any time, except to the extent that your physician/organization has taken an action in reliance on the use or disclosure in the authorization.

You have the right to inspect your PHI: Under federal law, however, you may not have or inspect the following records: psychotherapy/psychiatric notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to PHI.

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Website: www.ilanarosenbergphd.com

You have the right to request a restriction of your PHI: this means you may ask me not to use or disclose any part of your PHI for the purpose of treatment, payment or healthcare operations. You may also request that any part of PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician/organization is not required to agree to a restriction that you ma request. If your physician/organization believes it is in your best interest to permit use and disclosure of your PHI, your PHU will not be restricted. You then have the right to use another healthcare professional.

You have the right to obtain a paper copy of this notice from me.

You have the right to receive an accounting of certain disclosures, if any, I have made of your PHI. I reserve the right to change this notice and will inform you of any changes. you then have the right to change this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notices.

Complaints: You may complain to me or the Secretary of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Bldg., 200 Independence Ave., S.W., Room 509F, HHH Building, Washington DC, 20201, if you believe your privacy right has been violated by me. I WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.

This notice is effective as of April 14, 2003.

I am required by law to maintain the privacy of, and provide individuals with this notice of my legal duties and privacy practices with respect to PHI.

Signature below is only to acknowledge that you have received this Notice of Privacy Practices.

Print Name:_____

Signature: _____

Date: _____

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Phone: 201-921-3560
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Credit Card Authorization Form

Cardholder Name: _____

Billing Address: _____

_____

Email: _____

Credit Card #: _____

Expiration Date: _____

Card Identification #:
(Last 3 digits located on back of card) _____

Intake Fee: 250 Session Fee: 200

I authorize Dr. Rosenberg to charge the agreed upon amount per session to my credit card provided herein.
In the event of a missed session, without 24 hr cancellation, I understand that I will be charged the said session fee.

Cardholder - Print Name, Sign and Date below:

Print Name: _____

Signed: _____

Date: _____