Robyn Schwartz, LCSW

297 Kinderkamack Road

Suite 212

Oradell, NJ 07649

Privacy Notice and Insurance Release

Name____Referred by _______________

____

Date of Birth____________ Gender_____ (If a child Parent name) ________________

Address______________________________Town__________________zip________

Email address____

Home phone ______________Cell phone_____________Work phone______________

Emergency Contact____

Insurance Policy holders name, relationship and DOB______________________________

Employer____

Authorization of Payment and Release of Information for Insurance Benefits

I certify that to the above information is correct. I have provided a copy of my insurance card and authorize my insurance benefits to be paid directly to Robyn Schwartz, LCSW. I understand I am responsible for any copayment or in the event I do not have insurance to the agreed upon fee. I understand I am financially responsible to pay the fee if the insurance company is unable to or refuses to provide reimbursement. I also authorize Robyn Schwartz to release relevant information requested by my insurance company for the purpose of processing my insurance claim.

I also acknowledge that I have received a copy of the privacy notice. I authorize Robyn Schwartz to provide notice to me by telephone or verbally in the event of a breach of my protected health information (PHI). Such conversation shall be documented by Robyn Schwartz. Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of Robyn Schwartz.

_____________________________________Date__________

Signature

_____________________________________Date__________

Witness

rev. 3/2017

Bergen Therapy Associates
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Welcome

Welcome to my practice. This document contains important information about my professional services and my business policies. Its purpose is to inform you about my background and to make sure you understand our professional relationship. Please read it carefully and feel free to ask any questions. Your signature below will represent an agreement between us.

I earned a Master of Social Work degree from Adelphi University in 1982 and have completed extensive postgraduate training in providing psychotherapy services. I work with adults, adolescents, and children.

Psychotherapy is not easily described. For you to get the most out of it you will need to be a very active participant. You will be asked to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, psychotherapy often leads to better relationships, solutions to specific problems and significant reduction in feelings of distress.

Our first few sessions will involve an evaluation of your needs. I will provide you with some first impressions and some ideas of what might be accomplished in therapy. We will develop a treatment plan together. If you have any questions about my procedures please feel free to discuss them at any time.

Billing and Payment

I am "in network" for many insurance companies. If you have a co-pay, fee, or your deductable needs to be met, it will need to be paid at the end of each appointment. In the event your coverage does not cover my services my fee is $225 for an initial appointment and $200 for ongoing treatment. If your insurance company does not pay you will assume full responsibility to pay for the services provided to you. Cash or personal checks are acceptable. I will provide you with a receipt for all fees paid at your request. If you feel your financial situation warrants a reduction in your fee and we have not already spoken about this please discuss a fee adjustment with me.

In the event you will not be able to keep an appointment, you must notify me 24 hours in advance. Without advance notice you will be responsible for paying a $50.00 cancelation fee. Missed sessions are not reimbursed by insurance. If you cancel with less than 24 hour notice and the circumstances are extenuating, please speak to me about waiving the payment.

Confidentiality
All information you share with me is confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law. I am required to disclose a reasonable suspicion of child, dependant, or elder abuse; when a client presents a danger to self, to others; or if I am ordered by a judge to disclose information.

Contact information
I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail. I will make every effort to return your call on the same day that you make it. If you are unable to reach me and feel that you cannot/should not wait for me to return your call, you can contact the nearest emergency room and/ or the county emergency line 201 262 HELP (4357). If I schedule time away and cannot be reached, I will inform you, will change my voice mail message, and provide a covering therapists contact information.

Although I have provided an email address, I do not check my email regularly nor do I provide services online.

If you have any questions please feel free to ask.

Please sign indicating you have received a copy.

Robyn Schwartz, LCSW

date

Client/Parent signature

date