Jill Berlin, LCSW

OFFICE POLICIES AND GENERAL INFORMATION AGREEMENT FOR PSYCHOTHERAPY SERVICES

THE PROCESS OF THERAPY/EVALUATION

A typical therapy session lasts 45- 50 minutes, unless planned otherwise. If client is a minor, parents/guardians are expected to be onsite while children are within the counseling session and to appropriately supervise any children within the waiting area, so as to not disturb others. Please be considerate that other therapists will be in counseling sessions. I will always be available to discuss with you, your thoughts or feeling regarding therapy and its progress. Therapeutic approaches that may be used are play therapy, sandplay therapy, cognitive-behavioral therapy, family systems, developmental assessments, psychoeducational assessments, and EMDR. If Ms. Berlin is unable to provide an appropriate treatment that you would benefit from, she has an ethical obligation to assist you in obtaining those treatments from an appropriate provider.

CONFIDENTIALITY

All information disclosed within sessions and the written records pertaining to those sessions are confidential between client and therapist. All information revealed within a session may not be further revealed to anyone without your written permission, except where disclosure is required by law as described in the notice of privacy practices that you received with this form. If the client is a minor, I understand that I have the right to general information on issues and progress; however, the Treatment Provider and the minor child will hold some information shared in this professional relationship in confidence. To safeguard confidentiality and preserve the integrity of the therapeutic relationship, Jill Berlin, LCSW does NOT voluntarily become involved in client legal matters (e.g., custody, visitation, litigation against another, etc.).

WHEN DISCLOSURE IS REQUIRED BY LAW

Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; and where a client presents a danger to self, to others, to property, or is gravely disabled (for more details see also notice of privacy practices form).

EMERGENCIES

If there is an emergency during our work together, or in the future following termination, where Jill Berlin, LCSW becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, she will do whatever she can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive proper medical

care. For this purpose, she may also contact the police, hospital, or the person whose name you have provided on the biographical sheet.
Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. Jill Berlin, LCSW has no control or knowledge over what insurance companies do with the information she submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance.

CONFIDENTIALITY OF E-MAIL, CELL PHONES, AND FAX COMMUNICATION

It is very important to be aware that e-mail, cell phone communication, including text messaging, can be relatively easy to access by unauthorized people and, hence, the privacy and confidentiality of such communication can be easily compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can be sent erroneously to the wrong address. Please notify Jill Berlin, LCSW at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above mentioned communication devices. Jill Berlin, LCSW advises that any information that you consider privileged and do not want to risk a compromise of confidentiality should not be transmitted using any of the above-mentioned forms of communication. Please do not use e-mails or faxes in emergency situations.

CONSULTATION

Regarding consultation procedures, there may be occasion when Jill Berlin, LCSW may need to consult with clinical supervisors and/or other necessary professionals regarding treatment and/or in the interest of protecting the safety of the client or another whom may be at risk. In these situations she will make every effort to maintain confidentiality; however, in a situation of mandatory reporting she will be required by law to disclose certain identifying and situational information.

TELEPHONE AND EMERGENCY PROCEDURES

You can contact Jill Berlin, LCSW between sessions at (848) 252-1350. Ms. Berlin will return phone calls during office hours. If an emergency situation arises and you need immediate assistance, please be advised that you can call the Riverview Medical Center hotline, which is a 24-hour crisis line (732) 530-2438, the Police (911), or the 24-hour psychiatric emergency number at Jersey Shore Hospital,(732) 776-2325.

MEDIATION AND ARBITRATION

All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation before, and as a precondition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of Jill Berlin, LCSW and you, the client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Monmouth County, New Jersey in accordance with the rules of the American Arbitration Association, that are in effect at the time the demand for arbitration is filled.

TERMINATION

You have the right to terminate therapy at any time. If you choose to do so, Ms. Berlin will be more than willing to provide you with the names and numbers of other qualified professionals whose services you might prefer.

I have read and understand the above agreement and office policies, and by my signature below acknowledge my willingness to comply with them:

_____	_____	_____
Client name (print)	Client Signature	Date

IF CLIENT IS MINOR

_____	_____	_____
Parent/Guardian name (print)	Parent/Guardian Signature	Date

_____	_____	_____
Therapist name (print)	Therapist Signature	Date