Dana Septimus, Ph.D.
80 Broadway Cresskill, NJ 07626 ~ 201-906-9034
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Welcome! I understand that the decision to seek therapy for your child is a very important one, and am honored that you have decided to work with me. I would like to take this opportunity to acquaint you with information relevant to treatment, confidentiality, and office policies.

Client Information and Office Policy Statement

Financial Terms/ Insurance: Payment is due every session. There will be a $25 charge for any returned checks. In addition to therapy appointments, fees may be prorated for time spent for other professional services rendered. Other services may include, but are not limited to, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, and preparation of records or treatment summaries. If you become involved in legal proceedings that require psychologist's participation, you will be expected to pay for this time, even if called to testify by another party. The fees for professional time related to legal involvement (e.g., preparation and attendance at a legal proceeding) differ from that of the therapy session fee and will be discussed at that time. If you fail to meet your financial responsibilities within 60 days and arrangements for payment have not been agreed upon, your account may be turned over to a collection agency or appropriate court. If such action is necessary, you will be responsible for any expenses incurred.

Insurance Reimbursement: Please note that Dr. Septimus is an out-of-network treatment provider and does not participate on any health insurance panels. Most insurance plans offer an out of network benefit for mental health. Please check with your insurance carrier regarding the details of your plan. It is your responsibility to find out about your coverage (e.g., deductibles, number of covered sessions, authorization needed to begin therapy, etc.). At your request, a form that you can submit to your insurance for reimbursement as outlined by your plan can be provided.

Cancelled/Missed Appointments: A scheduled appointment means that time is reserved only for your child. If an appointment is missed or cancelled with less than 24 hours notice, you will be billed at your usual fee. Repeated missed appointments may result in termination from treatment.

Confidentiality: Issues discussed in therapy are generally confidential. However, there are limits to confidentiality. These situations include: 1) suspected abuse or neglect of a child, elderly person, or a disabled person, 2) when your therapist believes that your child is in danger of harming him/herself or another person, 3) if you or your child report that you intend to physically injure someone, the law requires your therapist to inform that person as well as legal authorities, 4) if your therapist is ordered by a court to release information, 5) when your insurance company is involved (e.g., filing a claim, insurance audits, case review, etc.), 6) in natural disasters whereby protected records may become exposed, or 7) when otherwise required by law. You may be asked to sign a Release of Information so your therapist may speak with family members or other professionals involved in your child's care.

Contacting Dr. Septimus: Dr. Septimus may not be immediately available by telephone. Please leave a voicemail, which is checked frequently, and your call will be returned as quickly as possible. If it is a clinical emergency, and the phone is not answered immediately, contact your family physician or go to your nearest emergency room. Please see additional form regarding email communication. It is requested that you do not use text messaging as a mode of communication.

Client Satisfaction: Dr. Septimus is committed to working with you and your child to the best of her ability. Feedback about your therapy experience is welcomed, particularly while your child

is in treatment. If you have any concerns at any point with the course of treatment, please do not hesitate to speak candidly about it.

Consent for Treatment: You authorize that Dr. Septimus may carry out psychological examinations, treatment, and/or diagnostic procedures that now or during the course of your care are advisable. You understand that the purpose of these procedures will be explained to you upon request and subject to your agreement. You also understand that while the course of therapy is designed to be helpful, it may, at times, be difficult and uncomfortable.

I UNDERSTAND AND AGREE WITH THE ABOVE POLICY STATEMENTS AND HEREBY SIGN:

_____	_____
Child's Name	Name of Child's Parent/Guardian
_____	_____
Signature of Client's Parent/Guardian	Date
_____	_____
Signature Adolescent 14 and older	Date

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Email Consent Form

This form is used to obtain your consent to communicate with you by email regarding your protected health information (PHI).
Dr. Septimus offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes.
Risks include, but are not limited to:

- Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Email senders can easily misaddress an email or text and send the information to an undesired recipient.
- Backup copies of emails may exist even after the sender and/or the recipient has deleted his or her copy.
- Employers and online services have a right to inspect emails sent through their company systems.
- Emails can be intercepted, altered, forwarded or used without authorization or detection.
- Email can be used as evidence in court.
- Emails may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

Dr. Septimus will use reasonable means to protect the security and confidentiality of email information sent and received. However, Dr. Septimus cannot guarantee the security and confidentiality of email or SMS communication and will not be liable for inadvertent disclosure of confidential information.

Patient's Acknowledgment and Agreement
I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Dr. Septimus and myself. I consent to the conditions outlined herein. Any questions I may have had were answered. I agree and consent that Dr. Septimus may communicate with me regarding my protected health information by e-mail.

Patient's Name: _____Signature:_____

Name of Parent/Guardian (if applicable):_____

Co-Signature of Adolescent 14 and older (If applicable): _____

Date: _____

Email address: _____

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INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES

Prior to starting video-conferencing services, you agree to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the other person(s).
- We agree to use Doxy.me for our virtual sessions. You will be sent a link to sign in and I am available to answer any questions about this platform. It is HIPPA complaint and I have signed a BAA with them.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- The fee for telepsychology sessions is the same as in-person sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

If you would like to discuss any of these items, please let me know.

Please complete the following information:
Emergency Contact Name and Number:
Closest Emergency Room:

Patient Name:
Patient Address:
Signature of Patient/Patient's Legal Representative:
Date:

Personal Data Form

Name: _____

Address: _____

Child's Age: _____ Birth date: _____

Gender: Male ____ Female ____

Name of Parents/Guardians: _____ _____

Parent/Guardian Phone Numbers:	Okay to call?	Okay to leave message?
Parent 1 cell: _____	Yes / No	Yes / No
Parent 2 cell: _____	Yes / No	Yes / No
Homel: _____	Yes / No	Yes / No

How were you referred to us? _____

Parent/Guardian Relationship Status (check applicable):

___ Single ___ Married ___ Divorced

___ Separated ___ Widowed ___ Domestic Partner

Child's School: _____

Grade: _____

Primary Care Physician and Phone Number: _____

Please describe the reason(s) for your child seeking treatment at this time:

Has your child ever received psychiatric or psychological treatment before? ___ Yes ___ No

If yes, please complete information below:

Dates	Name of Professional	Reason for Treatment	Was it Helpful?

Medical History

Name: Date:

1. Who is the physician who sees your child most often? _____
2. When was the last time your child had a physical check-up? _____
3. Has your child been treated by a physician or hospitalized in the last year? ___ Yes ___ No

If yes please specify _____

4. Has there been any change in your child's health in the past year? ___ Yes ___ No

If yes please specify _____

5. Is your child taking any medication (psychiatric, non-psychiatric, over the counter) at the present time?

___ Yes ___ No

If yes, please list (continue on back if needed):

Medication	Dosage/Frequency	Name of Prescriber

6. Has your child ever had a history of: (circle all that apply)

High/ Low Blood Pressure	Diabetes	Anemia	Seizures/Epilepsy
Cardiac Problems	Asthma	Tuberculosis	Cancer
Thyroid Problems	Ulcers	Tics	Other _____

7. Has your child ever been hospitalized for any emotional or psychiatric reason?

___ Yes ___ No

If yes, please complete information below:

Dates	Name of Hospital	Reason for Hospitalization	Was it Helpful?

8. Does anyone in your family have a history of mental health issues (e.g., depression, anxiety, alcohol, or drug abuse)? ___ Yes ___ No

If yes, please complete information below:

Family Member	List psychiatric, drug, or alcohol problem

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do Research
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Contact regarding privacy issues should be addressed to:

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80 Broadway Cresskill, NJ 07626
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dana.septimus.phd@gmail.com
Effective 8/2017

Acknowledgment of Receipt

I hereby acknowledge that I have received, read, and understood this Notice of Privacy Practices, and that any questions I have had about it have been answered.

_____	_____	_____
Print Name	Signature	Date