CLIENT REGISTRATION date:

First Name :_____ MI: _____ Last Name: _____ Age:_____ DOB:_____

Gender: _____ Marital Status: Married Single Employment: Employed Unemployed School_____

Last Year completed:_____ Student Status: Full Time Part Time

Email:_____ Email me appointment confirmations: Yes _____ No_____

Street Address:_____ City _____ State:_____ Zip:_____

Cell Phone Number: _____ Home Phone Number: _____
Which number do you give permission to leave detailed messages to: _____

Who referred you?_____ Diagnosis (if known): _____

Please list any medications (including over-the counter: _____

Prescribing physician(s) name and phone number(s):_____

For the purpose of treatment continuity, do we have permission to contact your physician(s): Yes _____ No _____

Prescribing physician(s) name and phone number(s):_____

For the purpose of treatment continuity, do we have permission to contact your physician(s) _____yes _____no

RESPONSIBLE PARTY INFORMATION

First Name :_____ MI: _____ Last Name: _____ DOB:_____

Gender: _____ Relationship To Client: _____ Occupation:_____

Street Address:_____ Cell Number: _____

City_____ State:_____ Zip:_____ Home Number: _____

Employer:_____ Work Phone #_____

INSURANCE INFORMATION - All services are out of network

Insurance Company: _____ Phone #: _____

Insurance ID Number: _____ Insurance Policy Group: _____

EMERGENCY CONTACT INFORMATION

Name:_____ Phone #: _____

Relationship to client:_____

ASSIGNMENT AND RELEASE
I hereby assign, transfer and set over to Jenna Siciliano, MA, LPC, NCC LLC, all of my rights, title, and interest to my reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Client Signature:_____ Date: _____

Witness/parent signature:_____ Date: _____

Jenna Siciliano, MA, LPC, NCC LLC
2517 Highway 35 · Building M · Suite 205
Manasquan, NJ 08736
phone: 732-508-0535
e-mail: JennaSicilianoLPC@gmail.com

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

When we examine, diagnose, treat, or refer you we will be collecting Protected Health Information. We need this information 1) to provide treatment 2) to collect payment 3) for health care operations. By signing this form you are agreeing to let us use your information for these stated purposes. The Notice of Privacy Practices explains in more detail how we use your information.

IF YOU DO NOT SIGN THIS CONSENT FORM, WE CANNOT TREAT YOU.

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices:

_____ _____
Signature **Date**

_____ _____
Signature **Date**

By signing below, I consent to use and disclosure by my provider and his business associates of my protected health information for purposes of treatment, payment, and healthcare operations.

_____ _____
Signature **Date**

_____ _____
Signature **Date**

***Client copy- retain pages 3 + 4 for your records!**

HIPAA:
Notice of Therapist Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW THERAPY AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We (heretofore Jenna Siciliano, MA, LPC, NCC LLC) may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- “PHI" refers to information in your health record that could identify you."
- "Treatment, Payment and Health Care Operations"
    - Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
    - Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
    - Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within our practice group such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of practice group such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization We may use or disclose 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 an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have reasonable cause to believe that a child has been subject to abuse, we must report this immediately to the New Jersey Division of Youth and Family Services.
- **Adult and 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.
- **Health Oversight:** If the New Jersey State Board of Marriage and Family Therapy Examiners issues a subpoena, we may be compelled to testify before the Board and produce your relevant records and papers.
- **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.
- **Serious Threat to Health or Safety:** If you communicate to us a threat of imminent serious physical violence against a readily identifiable victim or yourself or to the public and we believe you intend to carry out that threat, we must take steps to warn and protect. We also must take such steps if we believe you intend to carry out such violence, even if you have not made a specific verbal threat. The steps we take to warn and protect may include arranging for you to be admitted to a psychiatric unit of a hospital or other health care facility, advising the police of your threat and the identity of the intended victim, warning the intended victim or his or her parents if the intended victim is under 18, and warning your parents if you are under 18.
- **Worker's Compensation:** If you file a worker's compensation claim, we may be required to release relevant information from your mental health records to a participant in the worker's compensation case, a reinsurer, the health care provider, medical and non-medical experts in connection with the case, the Division of Worker's Compensation, or the Compensation Rating and

Inspection Bureau.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, we will send your bills to another address.)
- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may choose to provide you with a summary of your record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- **Right to an Accounting:** You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- **Right to a Paper Copy:** You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post such a notice in our offices and give you a copy at your next appointment.

V. Complaints:

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Jenna Siciliano immediately at 732-508-0535.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice went into effect on May 31, 2017.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by posting in our office and giving you a copy at your next appointment.

Jenna Siciliano, MA, LPC, NCC LLC

2517 Highway 35 · Building M · Suite 205
Manasquan, NJ 08736
phone: 732-508-0535

Office Financial Policy & Fee Schedule:

- Typical Psychotherapy Sessions are 45-50 minutes long (CPT 90834)
- Extended Psychotherapy Sessions are 60-75 minutes long (CPT 90837)

Following is a list of applicable fees:

·First meeting/ individual assessment:	$250
·Individual Sessions:	90834: $165
	90837: $215
·Group Therapy	$80 & up
·Fees for letters and/or reports:	$215 per hour
(reports & letters are not covered by *any* insurance)	
·Child Study Team Meetings:	$215 per hour plus travel time
·No shows/late cancellation fee:	same fee charged as per service
(48 hour cancellation policy)	requested
·Returned Check due to insufficient funds:	$100

Jenna Siciliano MA, LPC, NCC LLC is a FEE FOR SERVICE provider. Depending upon the acuity of the client 's situation, most clients meet weekly for individual sessions; group therapy meets weekly. Individuals that meet 52x per year for 45 minute sessions will pay approximately $8580; not everyone will choose to meet for weekly individual sessions. Group members that attend all 52 groups will pay $4160. *If there is an increase in acuity for a client and additional sessions are needed, then annual spending will increase. Some clients may occasionally have a longer session (90837), which will increase annual spending.

This office will have little-to-no contact with insurance companies. However, we will cooperate by supplying treatment request forms and information if it is required by your insurance company for reimbursement.

You are responsible to pay for your session each time we meet. Payment is accepted via cash, check, or IVYPAY for credit cards. The fee for returned checks due to insufficient funds is $100.00.

At no time is a therapist or employee from Jenna Siciliano, MA, LPC, NCC LLC expected to testify in court or supply information to the court. This means that if you are involved in custody issues or other litigations, you will refrain from having anyone from this office subpoenaed. Client relations are of the most importance and any legal involvement compromises this position.

You are responsible to pay on the day services are rendered. Accounts receivable that are aged more than 90 days will be sent to a collection agency. Charges will then include your balance plus collection agency fees, which may be as high as 40%.

We require **48 hours** notice to cancel an appointment without your being financially responsible for the time. **The fee for late cancellation is same fee charged per service.** Evening appointments are particularly desirable. If you cannot come, please let us know as early as possible. We will make every effort to reschedule you at a convenient time. **Missing two consecutive appointments or frequent cancellations/schedule changes will result in client discharge.** It is imperative to be consistent with therapy in order for results to occur.

I have read the above policy and understand it.

Signature _____ Date _____

Jenna Siciliano, MA, LPC, NCC LLC

2517 Highway 35 · Building M · Suite 205
Manasquan, NJ 08736
phone: 732-508-0535
e-mail: JennaSicilianoLPC@gmail.com

LATE CANCELLATION / NO SHOW FEES
CONSENT TO PARTICIPATE IN IVY PAY AND KEEP A CARD ON FILE

As per the fee agreement, we have a 48 hour cancellation policy. In the event that a non-emergency related cancellation is called in with less than 48 hours notice, you are responsible for the full amount of the session charges due.

The credit card listed below will be charged the day of the originally scheduled session in the entire amount due. In the event that you do not call in to cancel, the credit card listed below will be charged the day of your missed session for the full cost of the session. This applies to individual and group sessions.

By signing this form you are agreeing to: 1) keep a copy of a valid credit card on file with Ivy Pay Therapist Billing Platform, 2) have the physical signature below represent a valid signature on file, and 3) give permission to Jenna Siciliano, MA, LPC, NCC LLC to charge the card on file for any and all sessions where payments are due and not otherwise given. We will under no circumstance disclose your credit card information and is solely obtained and charged for session payments as authorized by the signature below.

By signing below, I acknowledge that I have given permission to Jenna Siciliano, MA, LPC, NCC LLC to charge my credit card with my signature provided for all sessions where payment is not otherwise given by another means of payment:

_____ _____

Signature For Consent **Date**

12/28/2021

Consent to Share information

Jenna Siciliano, MA, LPC, NCC LLC
2517 Highway 35 · Building M · Suite 205
Manasquan, NJ 08736
phone: 732-508-0535

Re: (client name)_____Date: _____

I give permission to **Jenna Siciliano, MA, LPC, NCC LLC** to obtain and/ or release information to:

_____

(Name of organization + contact information for best person to coordinate care with)

The purpose of this contact is: Treatment continuity and support

_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that Jenna Siciliano, MA, LPC, NCC generally may not condition psychotherapeutic services upon my signing an authorization unless the psychotherapeutic services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy rule.

_____ _____
client date

_____ _____
witness (when available) date