

## Healing Path Counseling, LLC

**Karen Ognibene, MA, LPC**

Carter Building

44 Cooper Street, Suite 204 Telephone:

609-230-6280

To New Clients,

I am looking forward to meeting with you soon. I am asking you to complete this paperwork prior to our meeting so that we will not have to take time in our session to address these administrative details. Please complete the following forms that are relevant to you and mail or fax them to me with payment for the initial consultation.

The *Client Data Form* provides me with basic identifying and contact information about you.

Please complete the *Release of Information Form* if you are under care of a psychiatrist by entering the name of the clinician/s in the spaces provided. Please make sure to enter contact information including fax number for any psychotherapist, psychiatrist or physician (if needed) you are currently seeing. We will discuss the possibility of my having contact with that clinician as part of an initial evaluation. I will not contact anyone without your knowledge and agreement.

The *Psychotherapist-Client Services Agreement* outlines my practice policies regarding financial matters, confidentiality of information, and other administrative issues. Please review this form completely then sign in the space provided at the end of the agreement.

The *Credit Card Form* is kept on file for no show/cancellation without 48 hours' notice. At this time, you may elect to pay by check, cash or credit card each session.

Thank you again for taking care of these administrative tasks prior to our initial meeting. We will be able now, to focus all of our time in session on the personal concerns you wish to consult me about.

Karen Ognibene, MA, LPC

**Karen Ognibene, MA, LPC**

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Carter Building, 44 Cooper Street, Suite 204, Woodbury, NJ 08096; Tel.: 609-230-6280

**REGISTRATION**

**Date:** \_\_\_\_\_

**Full name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone: Home:** \_\_\_\_\_ **Work:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

**Fax number:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Age:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Gender:** \_\_\_\_\_

**Referred By:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Employer/School:** \_\_\_\_\_

**Family Status:** \_\_\_\_\_

**Current Spouse/Partner's Name, Age & Occupation:** \_\_\_\_\_

**Children's Name/s, Age/s:** \_\_\_\_\_

**Name, address, phone of person/s to be contacted in an emergency:** \_\_\_\_\_

**Name, address, phone of treating psychiatrist/psychotherapist/physician:** \_\_\_\_\_

\_\_\_\_\_

**Current medications:** \_\_\_\_\_

\_\_\_\_\_

**What days of the week and blocks of time would you be available?**

\_\_\_\_\_

\_\_\_\_\_

**Emergency Information: Name:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Healing Path Counseling, LLC**  
**44 Cooper St, Suite 204**  
**Woodbury, NJ 08096**

**Authorization for Release of Information**

I, \_\_\_\_\_(client) hereby authorize Karen Ognibene, Licensed Professional Counselor, to exchange confidential information regarding my treatment with

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Contact Person to Correspond with	Contact Person Phone #
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This authorization permits the exchange of the following information for continuity of care:

_____ Presence in Treatment Only	_____ Presence & Progress in Treatment
_____ Diagnosis	_____ Treatment Plan
_____ Other(see below)	

Limited information Listed Here, Based on Necessity (please include topics & issues you are authorizing to be discussed and shared): \_\_\_\_\_

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I am fully aware that this correspondence may involve a conversation and/or transfer of written information.

I release my therapist, Karen Ognibene and Healing Path Counseling, LLC from any liability arising from the release of this information to the designated recipient and/or how the designated recipient utilizes said information.

I further understand that I need not sign this consent form in order to receive treatment and I am releasing this information on my own accord.

Any information received that is authorized by my consent shall not be further transferred without an additional written consent from me.

I may withdraw this consent at any time by writing a letter to Healing Path, LLC prior to information being disclosed, except in cases of "Presence in Treatment" letters.

I also consent Karen Ognibene and Healing Path Counseling, LLC alerting the person/agency that the release of Information was revoked.

Consent Valid On: \_\_\_\_\_ Consent Expires On: \_\_\_\_\_

\_\_\_\_\_  
Client Signature Date

\_\_\_\_\_  
Karen Ognibene, MA, LPC Date

# PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT

## WELCOME TO MY PRACTICE

**This document reflects the policies of Karen Ognibene, MA, LPC regarding fees, privacy of records and confidentiality of information, and other administrative issues related to the provision of professional services to the client.**

**Psychotherapy Services:** Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and Client, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have 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 has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

**Our first few sessions will involve an evaluation of your needs.** By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

**Meetings:** I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45-minute session (one appointment hour of 45 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation or unless we both agree that you were unable to attend due to circumstances beyond your control. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. If it is possible, I will try to find another time to reschedule the appointment.

**Professional Fee:** My session fee is \$175. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. Except in situations where the Clinician assesses the Client to be at risk of self-harm or harm to others, phone contacts with family or friends will not be made by the Clinician unless approved by the Client in advance with a signed release of information form. If you become involved in legal proceedings that require my participation,

you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge \$300 per hour for preparation and attendance at any legal proceeding. There is a \$10 fee increase at the start of each calendar year.

**Missed Appointments:** The Client agrees that if s/he is unable to keep an appointment, s/he will provide a minimum of 48 hours prior notice to the Clinician by texting the Clinician's cell phone or by speaking to the Clinician directly. Email is not adequate notice. **If an appointment is canceled or missed without 48 hours' notice, the Client understands that s/he will be billed for the session.** In this event, the bill will reflect a late cancellation and not a clinical session.

**Payment Method: Appointments are to be paid for at the time with check, cash, or credit card. As a fee for service provider, I will give you a receipt for services that you may submit on your own to your insurance company. (Note: I am Licensed Professional Counselor in the State of New Jersey; I am an out of network provider for all insurance companies).** Payment schedules for other professional services will be agreed to when they are requested. If, for whatever reason, the Client's account remains unpaid after 30 days following the monthly billing, the Clinician reserves the right to suspend or discontinue treatment until the charges are paid in full or a suitable payment arrangement is agreed to in writing by both the Client and the Clinician. If payment is not made in accordance with this arrangement, there will be a brief time period devoted to terminating treatment during which the Clinician will offer referral assistance to the Client. If legal means are required to secure payment, the Clinician's reasonable legal costs will be charged and payable by the Client. I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

**Insurance and Third-Party Payments:** The Clinician does not accept direct insurance assignments. At the Client's request, a monthly statement will be provided to the Client that can be submitted to the insurance company for reimbursement. Also, at the Client's request, the Clinician will provide relevant clinical information to the insurance company for reimbursement purposes. The Client should be aware that most insurance companies require a clinical diagnosis. The Clinician assumes no responsibility for the continuing confidentiality of the information once it is released to the insurance company.

**Contacting Me:** Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office between 10 AM and 7:30 PM, Monday through Friday, I will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. **I will make every effort to return your call promptly, with my checking messages at least once a day on weekends and holidays. If your call is very important, please let me know that in your message.** If you are difficult to reach, please inform me of sometimes when you will be available. **If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or go to your nearest emergency room where trained professionals will be able to assist you. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary, and will leave this colleague's name and phone contact on my outgoing message tape.**

**Emails and texts:** Often, clients prefer to email or text. It is important to know that these means of communication are not secured. **Please make sure to leave any message that needs privacy on my cell phone (609-230-6280).**

**Intake Process; Clinical Consultation:** During the intake process, the Clinician will explore with the Client the nature of the Client's concerns and will determine whether the Clinician can treat the problem as presented, or whether a referral to another Clinician would be more appropriate. The fee will be charged for the consultative services provided by the Clinician during the intake process. The Client understands that until a plan of treatment has been developed and agreed upon by both Clinician and Client, all services provided are consultative in nature and the Clinician shall assume no obligation to provide continuing services to the Client. In the event the Clinician recommends services elsewhere, the Client will be offered referral assistance. The clinical billing code for sessions will be billed as *Individual Psychotherapy (CPT Codes 90834)*. A provisional diagnosis will be given on the bill for purposes of Client reimbursement from the insurance carrier. This diagnosis is subject to change based on further assessment.

**Confidentiality:** All communications between Client and Clinician are confidential. Information will only be released to a third party under the following conditions: a) the Client authorizes the Clinician to release information with the Client's written permission; b) the Client is threatening serious bodily harm to self or another; c) the Clinician learns that a child, an elderly person or a disabled person has been or is being abused; d) pursuant to a court order in a judicial proceeding; e) or as requested in a professional board investigation. The Client understands and agrees that the Clinician's working notes are not considered part of the clinical record and will not be released to the Client or to any other persons, agencies or organizations under any circumstances. The Client understands and agrees that any records obtained from other clinicians, agencies, or institutions also will not be released by the Clinician under any circumstances. The clinical record shall include dates of contact, diagnosis, any evaluation forms completed by the Client and any treatment plan forms. In clinical situations where more than one person is the 'Client', such as in couples or family consultation, evaluation, therapy or counseling, no information will be released without the written consent of **all** adults who participate. The Clinician will respond to any court order for records by providing only the dates of contacts and a general summary of psychotherapy/counseling activity. The Clinician will have broad discretion to release any information she deems relevant in situations (b) and (c) above where she believes the Client or others to be at risk of physical harm, physical or sexual abuse, molestation, or severe neglect. The Clinician may contact the parent or guardian of a minor-age Client if deemed clinically necessary. There are some situations where I am permitted or required to disclose information without either your consent or Authorization: a) if you are involved in a court proceeding and a request is made for information concerning the professional services I provided to you, such information is protected by the therapist-patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information; b) if a government agency is requesting the information for health oversight activities, I may be required to provide it for them; c) if a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself; d) if I am treating a patient who files a worker's compensation claim, I may, upon appropriate request, be required to provide otherwise confidential information to your employer. Clinical records of inactive cases will be destroyed after seven years.

**The Health Insurance Portability and Accountability Act:** (HIPAA) requires that Healing Path Counseling, LLC make available to you a description of how medical information about you may be used or disclosed and how you can get access to this information. This is called the Notice of Privacy Practices :<http://www.hhs.gov/hipaa/for-professionals/privacy/lawsregulations/index.html>.

**Termination of Treatment:** The Client may terminate treatment at any time without moral, legal or financial obligation beyond payment for services already rendered. It is expected that the Clinician and the Client will discuss the prospect of termination so that both parties will be clear about any details that might need attention as part of the termination process. If the Client fails to schedule a future appointment, cancels a scheduled appointment, or fails to keep a scheduled appointment, and does not contact the Clinician within 30 days of the date of last recorded contact, it will be understood that the Client has terminated treatment. The Clinician shall have no further obligation to the Client once treatment has been terminated. Should the Client make contact with the Clinician at a later date requesting additional services, the Clinician may choose to see the Client on a consultative basis, or may recommend that the Client seek services elsewhere. The Clinician also may terminate the treatment if she determines the therapy process to be unproductive and/or if he determines that the Client would be better served by other health or mental health practitioners. The Clinician will provide 30-days' notice of intent to terminate to allow the Client to make other treatment arrangements.

**Consultation with Colleagues:**

Please know that the Clinician consults with colleagues in order to ensure you are receiving the best care possible. No identifying information is utilized such as last name, geographic location, employer, etc. If you prefer your therapist not consult on your case, please inform her in writing via email.

**Presence in Treatment Letter:**

To request a letter, the request needs to be put in writing with the name, address, and email of the person/court to whom the letter is for, and the nature of the letter. Any letters requested with less than two weeks of notice will be assessed a \$25 fee. Please note, a contingency for "Presence in Treatment" letter will apply. This contingency will state the following: This therapist will alert you when Client is no longer compliant, has stopped treatment and/or treatment is complete.

The Client(s), by signing below, states that s/he fully understands and agrees to the policies stated on the pages above. Copies of this form are available on the Clinician's website. This also serves as an acknowledgement that you have received the Pennsylvania Notice Form that follows in this packet and read it.

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Client Signature \_\_\_\_\_ Date \_\_\_\_\_

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Client Printed Name \_\_\_\_\_ Date \_\_\_\_\_

**Healing Path Counseling, LLC**  
**44 Cooper St, Suite 204**  
**Woodbury, NJ 08096**

I, \_\_\_\_\_, understand that Healing Path Counseling, LLC cancellation policy is 48-hour notice. Without 48-hour notice, it is considered a No Show. I understand if I do not give a 48-hour cancellation notice, my credit card on file will be charged the full session fee (\$175 individual or phone, \$350 double). No receipts are given for missed appointments.

**Credit Card Payment**

**Card Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Expires Mo/Yr:** \_\_\_\_\_ / \_\_\_\_\_

**CCV Security Code:** \_\_\_\_\_

**Zip Code:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Card Holder:** \_\_\_\_\_

**Signature:** \_\_\_\_\_