JEWISH FAMILY SERVICE
OF THE LEHIGH VALLEY

New Client Checklist

Welcome and thank you for choosing Jewish Family Service of the Lehigh Valley for your counseling needs. Please complete the enclosed forms and return with a copy of the front and back sides of your insurance card(s) in the self-addressed stamped envelope provided.

- ☐ Welcome Form
- ☐ Telemental Health Consent Form
- ☐ Informed Consent
- ☐ HIPAA Acknowledgement
- ☐ Copy of Front and Back Sides Insurance Card(s)

2004 W Allen Street, Allentown, PA 18104 TEL: 610.821.8722
www.jfslv.org

JEWISH FAMILY SERVICE
OF THE LEHIGH VALLEY

Welcome

We are pleased to welcome you to Jewish Family Service of the Lehigh Valley. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you.

Client Information

Today's Date _____

Name _____
Last Name First Name Initial

Address _____ Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Email _____ Religion: _____

Birth Date _____ Age ____ Sex ☐ M ☐ F ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Notify in case of emergency _____ Phone _____

Insurance Information (including Medicare)

Person Responsible for Account _____
Last Name First Name Initial

Relation to Client _____ Birth Date _____

Address (if different from client) _____ Phone _____

City _____ State _____ Zip _____

Insurance Company _____ Phone _____

Insurance Company Address _____

Membership/Medicare I.D. # _____ Group # _____

Does this insurance require you to have a referral to see a Specialist? ☐ Yes ☐ No

Additional Insurance (including Supplementary)

Person Responsible for Account _____
Last Name First Name Initial

Relation to Client _____ Birth Date _____

Address (if different from client) _____ Phone _____

City _____ State _____ Zip _____

Insurance Company _____ Phone _____

Insurance Company Address _____

Membership/Medicare I.D. # _____ Group # _____

Does this insurance require you to have a referral to see a Specialist? ☐ Yes ☐ No

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Medicare/Insurance Authorization and Assignment of Benefits

Name: _____

Insurance Policy Number: _____

I request that payment of authorized Medicare and/or medical benefits be made either to me or on my behalf to Jewish Family Service of the Lehigh Valley for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of counseling information about me to release to my health insurance carrier and/or its legitimate agents any information needed to determine these benefits or the benefits payable for related service in accordance with HIPAA health information standards.

I hereby assign all benefits to which I am entitled, including Medicare, private insurance, or any other health plan to Jewish Family Service of the Lehigh Valley. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said Insurance. I hereby authorize said assignee to release all information necessary to secure payment.

SIGNATURE _____ Date _____

JEWISH FAMILY SERVICE
OF THE LEHIGH VALLEY

2004 W. ALLEN STREET
ALLENTOWN, PA 18104

610.821.8722 phone
610.821.8925 fax
info@jfslv.org
www.jfslv.org

Telemental Health Informed Consent

I, _____, hereby consent to participate in telemental health with, _____ , as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2. I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at_____ to discuss since we may have to re-schedule.

7. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____ and my emergency contact person's name, address, phone: _____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Signature of client/parent/legal guardian Date

_____ _____

Signature of therapist Date

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Informed Consent

Welcome!

Thank you for choosing **Jewish Family Service of the Lehigh Valley** for your counseling needs. We look forward to getting to know and hope your experience with us is helpful. JFS is a social service agency that provides mental health/behavioral health services. Our licensed clinical social workers receive ongoing supervision. You have been assigned your therapist based on your specific needs as well as scheduling considerations.

Psychotherapy and Counseling Services

During your first therapy session, you can expect your therapist to ask you a series of questions designed to better understand your needs and discuss your therapeutic goals. If it seems that you might be better served by a different provider, JFS will assist you by making an appropriate referral.

Our primary goal is to create a safe, secure, and non-judgmental environment in which you can develop a productive and collaborative relationship with your therapist and explore the challenging aspects of your life. Ultimately, we strive to help you make the changes you seek to improve your health and well-being. Because therapy involves exploring feelings about personal struggles and possibly trauma, you may also experience painful feelings that arise during a counseling session or outside, in your day-to-day life. It is important that you discuss these feelings with your therapist. We always encourage you to be an active participant in your therapeutic process.

Sometimes, your therapist might recommend additional support, such as group therapy, additional counseling, a psychiatric evaluation, or case management to address other needs. If this is the case, we will request a signed release of information so that we might have open communication with these additional support providers.

At some point, you and your therapist may decide that your goals have been addressed and that therapy is no longer needed. Alternatively, you may decide, for any reason, that you would like to finish or take a break in your therapy. In either case, you and your therapist will begin to discuss termination services a few weeks in advance so that we can support you and bring your sessions to a close in a way that benefits you. Should your therapist feel that you would be better served elsewhere, it is her/his ethical responsibility to discuss that with you and, if warranted, provide you with a referral for therapy elsewhere. This referral is not a guarantee of services with a new care provider.

Office Policies

Confidentiality: With the exception of certain specific situations described in our Pennsylvania Notice Form in accordance with HIPPA regulation (see attached), you have the absolute right to the confidentiality of your therapy. Generally, the limits of confidentiality include situations in which your therapist feels that you pose an imminent threat to yourself or to others, abuse of a child is suspected (that may be you, if you are a child or adolescent), or if a court order or federal subpoena is received. We cannot and will not tell anyone else what you share with your therapist, or even that you are in therapy at JFS, without your prior written permission.

Electronic Communication: If you decide to communicate with your counselor by email at some point, your therapist will be able to respond briefly by return email, but please be aware that email and other electronic media are not completely confidential.

Child and Adolescent Clients: Any child/adolescent under the age of 14 must have the explicit written permission of both parents/guardians in order to participate in treatment unless there is a legal custody agreement stating otherwise. A copy of this agreement is required before treatment can begin.

Is this consent for a child under the age of 14? ☐ Yes ☐No

Child's name: _____ Birthday_____

If yes, please sign here:

Signature of parent(s): _____ Date: _____

_____ Date: _____

Adolescents 14 and older who are voluntarily seeking counseling control their own records and confidentiality is enforced even with parents/guardians. If you are 14 or older, you and your ` will discuss certain treatment issues in which you may want to include your parents/guardians. These may include issues such as appointment times, treatment goals, family meetings, etc.

Parents/guardians are encouraged to support the confidentiality between the therapist and the child. As well, it is important to understand that any communication between the therapist and parent/guardian will be shared with the child in order to maintain trust and emotional safety in the therapeutic alliance.

Appointments: Appointments are scheduled with your therapist and will take approximately 45-50 minutes. Therapists and clients should make every effort to begin the appointment on time. Please provide JFS with at least 24 hours notice if you are unable to meet with your therapist at the scheduled time.

Crisis/Emergency Situations: We do not have 24-hour emergency or "on-call" coverage. If you believe you will need a therapist with 24-hour coverage we will be happy to make a referral. If you experience a psychiatric emergency, do not leave a message for your therapist, you should **call 911 or go to the nearest hospital emergency room** rather than waiting for your therapist to call you back. Crisis intervention for Lehigh County is 610.782.3127 and for Northampton County is 610.829.4801. Crisis intervention is specifically designed to handle mental health emergencies.

Financial Policy: Please call your insurance company to talk about the behavioral health benefits you have, as well as the co-pays expected. We accept Medicare and many private insurance plans. If a third party such as an insurance company is paying for all or part of your bill, we are normally required to provide a diagnosis. If you do not have health insurance, we may be able to provide you services with limited financial assistance.

I have read these policies of Jewish Family Service and I agree to abide by them while I am receiving services at your agency.

Client Signature _____ Date: _____

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Acknowledgment of Receipt

Notice of Jewish Family Service Policies and Practices to Protect the Privacy of your Health Information

I have read, or have had read to me, and understand the Pennsylvania Notice Form regarding protected health information. (PHI).

_____ _____

Client Name Date

JEWISH FAMILY SERVICE
OF THE LEHIGH VALLEY

PENNSYLVANIA NOTICE FORM

Notice of Jewish Family Service Policies and Practices to Protect the Privacy of your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL 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

Jewish Family Service 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 the counselor provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when counselor consults with another health care provider, such as your family physician or another psychologist or counselor.
    - *Payment* is when JFS obtains reimbursement for your healthcare. Examples of payment are when the counselor discloses 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 JFS 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, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of our practice, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

The counselor 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 your counselor is asked for information for purposes outside of treatment, payment and health care operations, the counselor will obtain an authorization from you before releasing this information. The counselor will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes your counselor has made about your conversation during a private, group, joint, or family counseling session, which the counselor keeps 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) the counselor has 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

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

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- **Child Abuse**: If the counselor has reasonable cause, on the basis of his/her professional judgment, to suspect abuse of children with whom the counselor comes into contact in his/her professional capacity, the counselor is required by law to report this to the Pennsylvania Department of Public Welfare (PDPW).
- **Adult and Domestic Abuse**: If the counselor has reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), the counselor may report such to the local agency which provides protective services.
- **Judicial or Administrative Proceedings**: If you are involved in a court proceeding and a request is made about the professional services the counselor provided you or the records thereof, such information is privileged under state law, and the counselor will not release the information without your written consent, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety**: If you express a serious threat, or intent to kill or seriously injure an identified or readily identifiable person or group of people and the counselor determines that you are likely to carry out the threat, the counselor must take reasonable measures to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent.
- **Worker's Compensation**: If you file a worker's compensation claim, the counselor will be required to file periodic reports with your employer, which shall include, where pertinent, history, diagnosis, treatment, and prognosis.

IV. Patient's Rights and Psychologist/Counselor'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, the counselor is 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 a counselor. Upon your request, your bills will be sent to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in counselor's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. The counselor may deny you access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, the counselor 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. The counselor may deny your request. On your request, the counselor 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, the counselor 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 the counselor upon request, even if you have agreed to receive the notice electronically.
- *Right to Notification of any Breach*: If there is a breach of your confidentiality, then JFS must inform you as well as U.S. Department of Health and Human Services. A breach means that information has been released without authorization or without legal authority unless JFS (the covered entity) can show that there was a low risk that the PHI has been compromised because the unauthorized person did not view the PHI or it was de-identified.

- *Self-Pay Right to Restriction:* If you are self-pay, then you may restrict the information sent to insurance companies.
- Most uses and disclosures of psychotherapy notes and of protected health information for marketing purposes and the sale of protected health information require an authorization. Other uses and disclosures not described in the notice will be made only with your written authorization. You must sign an authorization (release of information form) for releases unless it is for purposes already mentioned in this Privacy Notice (such as mandated reporting of child abuse, reporting of elder abuse, reporting of impaired drivers, etc.)
- *Right of Electronic Record:* You have the right to receive a copy of your PHI in an electronic format or (through a written authorization) designate a third party who may receive such information.

Psychologist/Counselor's Duties:

- The counselor is required by law to maintain the privacy of PHI and to provide you with a notice of the counselor's legal duties and privacy practices with respect to PHI.
- The counselor reserves the right to change the privacy policies and practices described in this notice. Unless the counselor notifies you of such changes, however, the counselor is required to abide by the terms currently in effect.
- If the policies and procedures are revised, the counselor will share a revised copy with you in session, or forward a copy to you by mail, or alternative means, such as e-mail, if you chose.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision made about access to your records, or have other concerns about your privacy rights, you may contact the Executive Director, at 610-821-8722.

If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to Executive Director, 2004 W Allen St., Allentown, PA 18104.

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.

You have specific rights under the Privacy Rule. The counselor and JFS will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on May 1, 2021.