Nina F. Rifkind, LCSW, LLC
Owner, Wellspring Counseling, LLC
76 Broadway, Suite 200E • Denville, NJ • 07834 • Ph: 973-216-4405 ▪ Fax: 973-453-6786

CLIENT REGISTRATION

Client Name:_____ Date of Birth:_____ *(Office Only Use)*:Dx:_____

Home Ph: _____ Cell Ph: _____ E-mail: _____

Street Address:_____City/State/Zip Code:_____

Preference for appointment reminders (Choose ONE): ☐ Text ☐ E-Mail ☐ Home Phone

How did you hear about the Provider? ☐ Insurance Company ☐ Psychology Today ☐ Dr. _____

☐ Friend/Family ☐ Other _____

Primary Insurance Information

Insurance Company:_____ Insurance ID /Subscriber's_____

Insurance Claims Address *(Behavioral Health)**:_____
Without the appropriate address, verified in advance, claims submitted on your behalf may result in a balance due.

Insurance Plan Name: _____ Group #:_____

Insurance Telephone (*Provider Services*):_____Subscriber's Employer:_____

Subscriber's Name/Relationship:_____ Subscriber's Date of Birth:_____

Address (If different than Client):_____

Outpatient Therapy: Copay/Coinsurance _____ Annual Deductible _____

NOTE: If you have secondary insurance, please refer to the policy regarding claims submission.

Assignment of Benefits

I authorize the release of any medical or other information necessary to process all claims. I also authorize payment of any benefits to **Nina F. Rifkind, LCSW, LLC** for services rendered.

I understand that I am financially responsible for all service charges including co-payments, deductibles, etc.

_____ _____
Signature **Date**

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POLICIES AND PROCEDURES

Welcome to my practice. Your first visit to a new therapist is very important, and you may have many questions. This document contains important information about my professional services and office policies. Please take time to read it carefully and let me know if you have any questions, or need further information.

The Process: Sessions are typically 45-50 minutes, held weekly, unless other arrangements are made. Your first few sessions will focus on gathering information about personal/family history, the issues you want to address and setting initial goals for treatment. Goals will be reviewed and modified as needed during your time in therapy. Deciding when to stop our work together should be a mutual process. First, we will discuss the possibility of meeting less frequently or scheduling "check-in" appointments. I recommend that we discuss a plan to end our sessions together, before you terminate treatment.

Privacy Practices: Use & Disclosure of Protected Health Information (PHI): If you utilize insurance you will be asked to authorize the use and/or disclose of certain PHI about you to your insurance carrier and their contracted affiliates for the purpose of receiving authorization and financial reimbursement for your treatment. When your information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. You have the right to revoke this authorization in writing except to the extent that the practice has already acted in reliance upon it. Electronic transmission, including e-mail and/or text message may be used to communicate regarding scheduling or insurance issues **ONLY If you prefer not to utilize this type of communication during your time in treatment, please notify me us writing at the address above.** A more detailed description of the Privacy Policy is available upon request. *Please note*: Discussions related to you or your child's therapeutic treatment, and/or content of sessions, will only be conducted via phone or in person.

Fees and Insurance: If you have not verified your coverage and have a deductible, be aware that you may owe the full amount for a certain number of sessions before your copay kicks in. If I am not in-network with your insurance, you are responsible for the fee of $180 per 45-50-minute individual sessions or $200 per family session, at the time of service. Upon request, a detailed receipt will be provided, that you may submit to your insurance company for reimbursement. While I may submit claims for clients using out-of-network benefits, it is your responsibility to follow-up with insurance if any issues with payment arise, and to ensure that your balance is paid within one month of session dates.

Please Note: Unless your primary insurance is Medicare**, if you have secondary insurance, the practice will submit claims to your primary insurance, only. Submission to the secondary insurance will be your responsibility. This second step is required to receive payment.** If we bill insurance and you mistakenly receive a reimbursement check, you are responsible for signing the check over to the practice and ensuring that it is received in a timely manner

Payment: The fee, or copay if you are using insurance, is to be paid at the start of each session unless other arrangements have been made. I accept cash, checks & most major credit cards, with receipts available by request.

POLICIES AND PROCEDURES *(Continued)*

In addition to weekly appointments, I charge in increments of my hourly rate ($200) for other professional services related to treatment, and for certain phone calls with clients. *(see Out-of-Session Services below*). Please notify me if any

problems arise regarding your ability to make timely payments. A ***break in treatment*** may occur if you carry a balance on your account for more than 1 month, or if your insurance company takes more than 1 month to send appropriate payment.

There will be a $30.00 charge for all returned checks due to fines imposed by the bank. Any outstanding balance that goes beyond 90 days may be sent to a collection agency. You are responsible for any fees incurred in connection with the use of a collection service or attorney, resulting from failure to maintain payment for services rendered.

Cancellations: All appointments must be cancelled with a minimum of **48 hours notice**. If this does not happen, you will be charged a $60 cancellation fee. This is not billable to your insurance company, and is payable at your next appointment. Exceptions may be made for emergencies and sudden illness**.** *If you are utilizing EAP sessions, this fee does not apply.*

Out-of-Session Services: Other services include, but are not limited to, report writing, collateral phone calls including MDs or attorneys, correspondence with school personnel or other treatment providers, preparation of records or treatment summaries. These services are billed in 15-minute increments based on an hourly rate of $200. Phone calls regarding you or your child's treatment that go beyond scheduling or a basic exchange of information are charged at $30 per 15-minute increment. These services are generally not covered by insurance.

Phone Calls between you and the therapist: There is no fee for phone calls that last less than 10 minutes; however, if a phone call goes beyond 10 minutes, the service will be billed as other Out-of-Session services, in 15-minute increments, in this case, based on an hourly rate of $160. I always do my best to return client calls within a reasonable time frame. I do not provide emergency/crisis therapy and direct you to St. Clare's 24 hr. Crisis Hotline at 973-625-0280 or 911 if, at any time, you need immediate support.

Chance Meeting in Public: In the interest of privacy and confidentiality, if I see you in public, I will not acknowledge or approach you. If you choose to approach me, that is fine. I will not speak about any issues related to therapy in public and our interaction will be brief. If such a meeting raises any concerns for you, we will discuss it thoroughly in our next scheduled session.

Social Media: For reasons related to professional ethics and boundaries, I will not connect with clients on any social media or professional web-based platforms.

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INFORMED CONSENT FOR TREATMENT

I _____, give consent and authorization for ☐ myself ☐ my child (Child's Name _____), to receive clinical services from Nina F. Rifkind, LCSW. This may include psychosocial assessment for the purpose of evaluation and or diagnostic and psychotherapeutic procedures for the purpose of treatment/counseling.

The confidentiality of the patient's medical record is required by law and will not be released without written consent except as required by law, as follows:

I. If I reasonable cause to suspect that a child is being abused or neglected, I must report this to the county's Child Protective Services or police.

II. If I have reasonable cause to suspect that an elder or dependent adult is being abused or neglected, I must report this to the appropriate county agency.

III. If I have reason to believe that you or your child may cause serious harm to
IV.
yourself/themselves or to another person, I will take protective actions. This may include contacting family members, seeking hospitalization, notifying any potential victims of violence, and/or notifying the police.

It is also important to be aware of other potential limits to confidentiality that include the following:

I. All records as well as notes on sessions and phone calls can be subject to court subpoena or order under certain extreme circumstances.

II. Most records are stored in a HIPAA compliant, cloud-based Practice Management Program but some are stored in locked cabinets or secured electronic devices.

III. Cell phones, faxes, and e-mails are used on some occasions.

I may occasionally participate in peer consultation about a case, with other mental health or health professionals. During a consultation, I make every effort to avoid revealing the identity of a client. The other professionals are also legally bound by the laws regarding confidentiality.

I have read this form and had any questions answered. I certify that I understand the above information and agree to its contents.

_____
Signature of Client

_

_____ _____
Signature of Parent or Legal Guardian **Date**

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AGREEMENT AND ENROLLMENT

I have read and received a copy of the Policies and Procedures, including the office Privacy Practices and have had any related questions answered. I certify that I understand the content of these materials and agree to abide by the specified guidelines, including the following:

- I agree to pay a charge of $60 in the event that I fail to show up for a scheduled appointment or fail to cancel at least **48 hours** in advance, unless it is mutually determined to be an emergency situation.
- I agree to pay for all charges not covered by my insurance plan.
- I authorize Nina F. Rifkind, LCSW to use and/or disclose certain Protected Health Information about me to my insurance carrier and their contracted affiliates for the purpose of receiving authorization and financial reimbursement for treatment.
- I understand that a break in treatment may occur if my insurance company does not send appropriate payment within 1 month of claim submission, or if I maintain a balance due for more than 1 month.
- I understand that any outstanding balance beyond 90 days may be sent to a collection agency. In that event, I agree to pay all fees charged by the collection agency as well as related legal fees.
- I agree to pay a $30 fee per check, for any checks that are returned to the office for non-payment.
- I understand that phone consultations that go beyond scheduling matters or a brief exchange of information will incur a fee of $30 per 15-minute increment.
- If my insurance sends me a reimbursement check that is meant for the office, I will sign the check, write on the back "pay to the order of Nina Rifkind" and forward the check to Nina Rifkind.

Client's Name (print)	Client's Signature	Date
Parent/Guardian's Name (print)	Guardian's signature	Date
Witness's name (print)	Witness's signature	Date

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EMERGENCY CONTACT RELEASE FORM

NAME: _____ **DOB:** _____

I hereby authorize Nina F. Rifkind, LCSW to release information to the following person in the event of a medical or mental health emergency:

Emergency Contact Name: _____

Address: _____

Phone number *(s)* (C) _____ **(H)**_____ **(W)** _____

For the purpose of: CARE DURING A MEDICAL OR MENTAL HEALTH *(SUICIDAL/HOMICIDAL)* EMERGENCY

The information authorized to be released *(Please INITIAL Below):*

Any information related to a medical concern or emergency _____

Any information needed to secure safety when suicidal or homicidal _____

I understand that, in order to protect the limited confidentiality of records, my agreement to obtain or release information is necessary, and that this permission is limited for the purposes and to the person listed above, and will be effective for one year after the date of my signature. A photocopy or facsimile of this form may be accepted in lieu of the original signed form. I also understand that this consent is revocable by submitting a written request to Nina F. Rifkind, except to the extent that action has been taken on it already.

I further understand that Nina F. Rifkind, LCSW will not condition my treatment on whether I give authorization for the requested disclosure.

_____ _____
Client Signature **Date**

_____ _____
Parent/Guardian Signature *(if child under age 14)* **Date**

_____ _____
Witness Signature **Date**

CURRENT HOUSEHOLD COMPOSITION:		
Name (*Last name is optional*)	**Relationship**	**Age**

TREATMENT HISTORY:

MENTAL HEALTH TREATMENT HISTORY:

Are you currently under the care of a psychiatrist?

If yes: What is the name of the psychiatrist?

What medications, if any, are currently prescribed?

Have you ever received outpatient mental health treatment?

With whom were you in treatment?

In what year and for how long were you in treatment?

What, if any medication(s) were you prescribed?

Have you ever received inpatient mental health treatment?

If yes: For what reasons did you seek help?

In what hospital did you receive treatment?

In what year and for how long were you in treatment?

What, if any medication(s) were you prescribed?

ALCOHOL AND SUBSTANCE USE:

Do you drink alcohol? ___ No ___ Yes
If Yes, what is your level of use? ___ Low ___ Social ___ Moderate ___ Heavy

In the recent past, have you ever thought, or been told, that your drinking adversely affects your relationships, work or mood? ___ No ___ Yes

Do you use Drugs? ___ No ___ Yes If Yes, please specify use below.

Have you used drugs in the past? ___ No ___ Yes If Yes, please specify past use below.

Substance	Age first used	Weekday Use/Amount	Weekend Use/Amount	Last used
r Marijuana				
r Cocaine/Crack				
r Methamphetamine				
r Heroin				
r Barbiturates/downers				
r PCP, LSD mushrooms, molly, ecstasy (hallucinogens)				
r Tobacco (any form)				
r Other:				

PHYSICAL HEALTH HISTORY:

List any medical or physical problems and when they were diagnosed:

List any major surgeries you've had and the date(s):

List any serious illness or injuries: