MENDING HEARTS
BEHAVIORAL HEALTH AND FAMILY SERVICES

CLIENT POLICIES AND PROCEDURES

Welcome to Mending Hearts Behavioral Health and Family Services. Please read this document thoroughly and initial each section.

_____ 1. **CONFIDENTIALITY**

I have read the privacy and confidentiality notice & patients' rights.

We do not share personal information with third parties for marketing/promotional purposes."

_____ 2. **TELEPHONE CALLS and TEXT MESSAGING**

If the occasion arises that the patient needs to talk with the counselor outside of normally scheduled appointments, leave a message, and the counselor will return calls within 24 hours. There will be a fee for calls that result in more than 10 minutes. There will be a 25.00 fee for each fifteen (15) minute interval. This fee will be the patients' responsibility as most insurances do not permit telephone counseling. Text messages may be used for canceling and rescheduling appointments. If the patient shares information other than scheduling, it will be discussed during the next session. Counselors will not counsel via text messaging.

You should call 911 or go to your nearest emergency room for life-threatening emergencies.

_____ 3. **LENGTH OF THE SESSION**

The initial session is scheduled for 60 minutes; subsequent sessions are 53-60 minutes for individuals and 45 minutes for couples and families. Please arrive on time for the scheduled session, as it will end at the scheduled time regardless of arrival time. Patients arriving at most 15 minutes late will need to reschedule unless prepared to pay out of pocket. The insurance will not be billed.

_____ 4. **FEES AND PAYMENT**

All payments are collected the day prior to services. Copays or fees may be made by cash, check, credit card, or through the patient portal. Cash and check payments must be made at the check-in window prior to services rendered. Patients counseled via video must leave a copy of his/her credit card on file in our secured database.

The self-pay session rate ranges from $60 – $225.00, depending on the services rendered. All overdue balances will be subject to collections after 30 days with a monthly interest fee of 2%.

_____ 4a. **REPORTS AND DOCUMENT REQUESTS**

A $30.00 fee will be assessed for medical records requests: $40 for document completion (FMLA, Disability, SS, Claims, and court case Summary Letters). Court subpoenas and other consultations will be $90hr. The client is responsible if the requesting agency does not cover the fee. Reports will not be provided until the counselor has seen the client a minimum of five (5) sessions. Additional time is at the counselor's discretion if he/she feels more time is needed to adequately assess the problem.

_____ 4b. **TELEHEALTH AND IN-PERSON COPAY**

Copays and fees for ALL appointments will be collected within 24 hours before the appointment.

_____ 5. **OUTSTANDING BALANCES**

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I authorize Mending Hearts Behavioral Health Family Services to charge my credit card for counseling services and any outstanding fees. I understand that my information will be saved on file for future transactions on my account.

_____ 6. **INSURANCE**

The insurance company will be billed for all sessions unless otherwise agreed upon. The patient is responsible for the copay or coinsurance. If, for any reason, the insurance company does not pay the claim after 90 days, the fee will become the patient's responsibility. A receipt will be provided to the patient to attempt to collect reimbursement from the insurance company.

If the patient's insurance changes or is terminated, please inform the front desk staff immediately. Benefits may change when the policies change or renews. Be sure to check to avoid surprise fees.

_____ 7. **CANCELLATIONS AND MISSED APPOINTMENTS**

When the patient's appointment is scheduled, the time slot is reserved for the patient weekly or bi-weekly unless an alternate arrangement is made with the counselor. The patient is expected to attend the regularly scheduled session unless a 24-hour notice of cancellation is provided. If an appointment is canceled, the patient is expected to keep the next regularly scheduled appointment. Appointments canceled with less than a 24-hour notice will be assessed a $75.00 late cancellation or missed appointment fee. If the patient arrives more than 15 minutes late, it is considered a missed appointment. The patient has the right to remain for the balance of the session but must pay out of pocket. The insurance company will not be billed.

There is a limit of 3 cancellations a month without an attempt to reschedule in the same week to keep a reserved slot unless an alternate arrangement is made with the counselor. If the reserved slot is lost, the patient will become a floating patient, and appointments will be scheduled based on counselor availability. Counselors reserve the right to transition inconsistent clients to floater status.

_____ 7a. I agree to permit Mending Hearts to use the card on file to clear late cancellations and no-show fees at the time of occurrence.

_____ 8. **INCLEMENT WEATHER POLICY**

A message will be left on the voice mail if the office is closed. Each counselor will have the right to reschedule his/her clients even if the office is open.

_____9. **SOCIAL MEDIA AND TELECOMMUNICATION.**

Due to the importance of your confidentiality and the importance of minimizing dual relationships, Mending Hearts Counselors do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). Adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when you meet with your counselor, and you can talk more about it. Feel free to follow the Mending Hearts business page.

_____10. **UNACCOMPANIED CHILDREN**

An adult must accompany children under 12 in the waiting area for safety purposes.

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_____11. **TELEHEALTH**

If regulations regarding telehealth change, I am aware that I may have to be seen in the office at Mending Hearts. Copays and fees for telehealth appointments will be collected within 24 hours before the appointment. I understand that there will be no recording of any of the online sessions by either party, and the confidentiality policy in #1 applies

I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth unless there is an exception to confidentiality (see Policy #1).

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 telehealth services are inappropriate. A higher level of care is required.

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

_____12. **COUNSELOR-TO-COUNSELOR COMMUNICATION.**

If my spouse and I or a family member see separate counselors at Mending Hearts, the counselors have my permission to converse concerning our cases to coordinate the best care for us.

_____13. **NO SECRETS**

I understand that if I am working on relationship or family problems, it's important to know that I am entrusting my therapist to use his/her professional judgment as it relates to individual confidence. By signing this form, you acknowledge that anything you communicate to me individually by phone, email, or any other means may be important to bring up and work on in a couples or family therapy session. My therapist reserves the right (but not the obligation) to do so.

_____14. **SOBER SESSIONS**

I understand that in order to have productive sessions, I must be sober. If my counselor detects that I am unfit to continue the session, it will be rescheduled and deemed a late cancellation

_____15. VIDEO COUNSELING ETIQUETTE

- Find a quiet place to have your sessions
- Your Wi-Fi needs to be adequate for the video session
- If you find your car is your only private space, it must remain parked during the session, and Wi-Fi needs to be available
- Try to maintain the confidentiality of your session as you would in the office
- Try to avoid distractions by children and other family members
- It is NOT permitted to participate in sessions from your bed or without shirts (men)
- You must be fully dressed as if you were in the office

- Your session time should not be your scheduled mealtime unless otherwise agreed upon with your counselor
- Your space must be sufficiently lit to show your face
- The counselors will maintain a professional environment and keep your sessions completely confidential
- The client agrees to attend sessions sober to accomplish goals established by the client and counselor.

_____16. **INFORMED CONSENT**

I understand that by entering the therapeutic process, I have taken a positive step toward my emotional well-being. I understand that the outcome of my treatment depends primarily on my willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I understand MHBH/FS cannot promise that my behavior or circumstances will change. MHBH/FS promises to support me and do their absolute best to understand me and my presenting problem, as well as to help me clarify what it is that you want for me.

_____17. **OUTSIDE CONTACT**

I understand that if my therapist/staff or I accidentally see each other outside of the therapy office, my therapist/staff will not acknowledge me first. My right to privacy and confidentiality is of the utmost importance to MHBH/FS, and the therapist/staff does not wish to jeopardize my privacy. However, I understand that if I acknowledge the therapist/staff first, he or she will be more than happy to speak briefly with you but deems it inappropriate to engage in any lengthy discussions in public or outside of the therapy office.

_____18. **CAMERA ONSITE**

I am aware there is a ring camera at the door that records those entering the building. I understand there are no other cameras in the building recording.

_____19. **DISCHARGE AND TERMINATION**

MHBH/FS will consistently implement criteria regarding discharge:

1. Clients will actively be involved in their discharge planning when treatment goals have been successfully met.

2. Services to clients may be terminated before successful discharge if the client does not follow the rules, regulations, and requirements of MHBH/FS

_____20. **FAMILY SUPPORT**

I acknowledge that family involvement is an integral part of the therapeutic process. I understand that I will be asked periodically to include family in my sessions as needed.

_____21. **PROXY SIGNATURES**

I understand all treatment plans must be signed, indicating my agreement with the goals and objectives for therapy. If I am unable to attend a session in person or access my portal for signature, I give my clinician permission to sign my treatment plan by proxy.

_____22. **CLIENT PORTAL**

I understand the client portal will be the primary method for receiving documents and the means of communication with the agency.

_____23. **CLIENT RIGHTS**

Clients have the following rights:

1. The right to be free from unnecessary or excessive medication See N.J.A.C 10:37-6.54
2. The right to not be subjected to non-standard treatment or procedures, experimental procedures or research, psychosurgery, sterilization, electro-convulsive therapy, or provider demonstration programs without written informed consent after consultation with counsel or an interested party of the client's choice. (See N.J.A.C. 10:37-6, Article XV).
    a. If the client has been adjudicated incompetent, authorization for such procedures may be obtained only pursuant to the requirements of N.J.S.A. 30:4-24.2d(2).
3. The right to treatment in the least restrictive setting, free from physical restraints and isolation, provided that a client in Inpatient Care may be retrained or isolated in an emergency pursuant to the provisions of N.J.S.A. 30:4-24.2d(3). See N.J.A.C 10:37-6, Article XV.)
4. The right to be free from corporal punishment.
5. The right to privacy and dignity.
6. The right to the least restrictive conditions necessary to achieve the goals of treatment/services.
7. MHBH/FS has a legal obligation to report, warn and inform in the case of:
    a. Child abuse and neglect
    b. Elder abuse
    c. Suicide ideation
    d. Homicide ideation

_____24. **CLIENT GRIEVANCES**

I understand that I can contact one of the following agencies to assist with a grievance that I may have concerning MHBH/FS and the services I receive.

Community Mental Health Law Project
4 Commerce Street
Mount Holly, New Jersey 08060
609-261-3453

County Mental Health Administrator
Shirla Simpson
Mental Health Administrator
Division Head, Division of Behavioral Health
Dept. of Human Services
795 Woodlane Road
Mount Holly, New Jersey 08060
609-265-5383
Email: ssimpson@co.burlington.nj.us

Division of Mental Health and Addiction
Services Ombudsperson
Susanne Mills
5 Commerce Way
P.O. Box 362
Hamilton, NJ 08625
609-438-4321

Division of Mental Health Advocacy
State of New Jersey
Justice Complex
25 Market Street
Trenton, NJ 08625
877-285-2844

Division of Child Protection and Permanency (for child abuse and/or neglect)
East Local Office

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100 Lucas Drive,
Lumberton, NJ 08048
609-265-6900
and
West Local Office
200 Campbell Drive
Willingboro, NJ 08046

609-880-9300
County Welfare Agency (for adult abuse)
Burlington County Board of Social Services
Office of Aging
795 Woodlane Road
Westampton, NJ 08060
609-261-1000

If you have any questions regarding these policies and procedures, please do not hesitate to contact our office. All clinical questions should be directed to your counselor or clinical director.

My signature certifies that I have read, fully understand, and agree to the Policies and Procedures document. I have also received a copy of this document.

_____	_____	_____
Client's Signature or Authorized Signature	Print Name	Date
_____		_____
Witness (Office Staff)		Date