

Sharon L. White, LCSW, LMFT
146 S. Lakeview Dr. Suite 300
Gibbsboro, NJ 08026
856-784-2500

Confidentiality Agreement and Use of Technology:

Client Name: (print) _____ Date: ____/____/2018

I value and respect the confidential information that is shared between us. Following the NASW (National Association of Social Workers) Code of Ethics Guidelines effective January 1, 2018, I ask you to sign the following agreement. This will assure that you have been informed of the recent updates in the Code of Ethics which refer to the technological developments that have emerged in the field of social work. Technology-assisted social work services encompass all aspect of social work practice, including psychotherapy; individual, family or group counseling; community organization; administration; advocacy; mediation; education; supervision; research; evaluation; and other social work services.

1. I will ask for your informed consent before making audio or video recordings of you or permitting observations of service provision by a third party.
2. When I provide services to families, couples, or groups, whether in-person or electronically, there is an agreement among the parties involved concerning everyone's right to confidentiality and obligation to preserve the confidentiality of information shared by others.
3. I will make reasonable efforts to ensure continuity of care if services are interrupted by situations such as unavailability, disruptions in electronic communication, relocation, illness, mental or physical ability, crisis work or death.
4. I will refer you to other professionals when the other professionals' specialized knowledge or expertise is needed to serve you fully or when I believe that you are not making reasonable progress and that other services are required.
5. If necessary, you agree to a confidential phone or facetime visit. It is expected that you can verify your identity and location and inform me if there is anyone else who would have access to our conversation. Insurance companies do not typically pay for these visits. I charge \$85 for a 45-minute phone or facetime consultation. Payments should be mailed within 7 days of service. Emergency calls will be accepted but calls longer than 10 minutes will incur a full- session charge.
6. I avoid accepting requests from or engaging in personal relationships with clients on social networking sites or other electronic media to prevent boundary confusion or inappropriate dual relationships.
7. It is advised that you use my email sw@peacefulpartners.com as this is encrypted for privacy concerns. However, it is expected that you refrain from sending any confidential information through email, text or other forms of social media to avoid any possibility of the information being hacked or compromised in any manner.
8. You are informed and give consent that I may contact you and you may contact me and leave a confidential message.
9. Please check if I may securely contact you at: Home phone: ____ Cell phone: ____ Text message: ____ Email: ____
Fax: ____ Voice mail cell: ____ Voice mail home: ____ U.S. Mail: ____ Other: (specify) _____

If you have any questions or concerns, please contact my confidential voice mail at 856-784-2500 or Fax: 856-784-7700. Thank you. Sharon White, LCSW, LMFT

Print Name: _____ Client Signature: _____ Date: ____/____/18

Witness: _____ Sharon L. White, LCSW, LMFT

FEE POLICY

Each scheduled hour is reserved for you and it is very important that you keep your appointment. Please read carefully and sign below indicating your agreement:

1. I agree to participate as scheduled and if I need to cancel an appointment I will contact the office at least 24 hours in advance.
2. If I fail to provide sufficient notice, I will be charged a \$50.00 no show/cancellation fee, which I agree to pay. Please understand it is usually not possible to fill a vacant appointment without sufficient notice.
3. I agree to bring my health care membership card to my session in order that the Agency may obtain a copy of my insurance card before any services are rendered and I agree that if there is a change in my insurance policy, including a need for prior authorization for visits, that it is my responsibility to contact my insurance company for an authorization and inform Sharon L. White, LCSW that there is a change in my insurance. I will be responsible for payment of visits in which I initially neglect to do so.
4. I understand that the co-payment is established by the health plan and co-payments generally range from \$5.00 to \$50.00 per session.
5. I understand that I am responsible for all insurance deductibles.
6. I understand that payment of services is expected at the time of the appointment. Exact change or payment by check would be appreciated.
7. I understand that if I cancel 2 or more appointments in a row, my therapist may suspend services.
8. I understand that if I do not comply with any of these policies due to emergencies that I will be able to speak with my therapist to evaluate the situation with me.
9. Please do not ask for a "professional courtesy." The Health Insurance Portability and Accountability Act of 1996 (HIPAA), better known as the Kennedy-Kassebaum bill states that it is illegal for a provider to not collect the full copay

I UNDERSTAND AND AGREE WITH THE ABOVE POLICIES

Print Name: _____ Signature: _____ Date: ___/___/2018

Witnessed and Reviewed by Sharon White, LCSW _____ Date: ___/___/2018

AUTHORIZATION/RESPONSIBILITY AGREEMENT

INSURANCE

I hereby authorize any insurance company to pay the proceeds or any payment due me for behavioral health treatment or services to Sharon L. White, LCSW. A copy of this can be considered as an original for insurance purposes.

RELEASE OF INFORMATION

I hereby authorize Sharon L. White, LCSW to release to my insurance company or its representative (including any employee, agent or subcontractor of the insurer) any information including the diagnosis and the records of any treatment or examination rendered to me during the period of any Behavioral Health care are or for/to any other medical facility that may need it to obtain records for treatment.

MEDICARE

If applicable I request that payment of authorized Medicare benefits be made on my behalf to Sharon L. White, LCSW for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Center for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

MEDIGAP

If applicable I request that payment of authorized Medigap benefits be made on my behalf to Sharon L. White, LCSW. I authorize any holder of Medicare information about me to be released to my Medigap Insurance Carrier including any information needed to determine these benefits payable for related services.

NOTICE OF PRIVACY

I acknowledge that I was provided a copy of the **Notice of Privacy** for Sharon L. White, LCSW
If person signing is not the client, please print your name and relationship to client:

Client Name (print) _____ Signature _____ Date ____/____/2018

Address _____ City _____ State _____ ZIP _____

Relationship to client: Self _____ Spouse: _____ Parent: _____

Witnessed and reviewed by: Sharon L. White, LCSW _____ Date ____/____/2018

SHARON WHITE, SSJ, MSW, D.MIN, LCSW

146 S. Lakeview Dr.
Suite 300
Gibbsboro, NJ 08026
856-784-2500 (FAX 784-7700)

Consent to use and disclose your health information

This form is an agreement between you, and me/us. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send to others. The Notice of Privacy Practices (NPP) explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our Web Site, <http://www.peacefulpartners.com> or by calling us at 856-784-2500 or from our Privacy Officer.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

CLIENT (PRINTED) _____ SIGNATURE: _____

Date received Notice of Privacy Policy: _____ / _____ /2018

Witnessed and reviewed by Sharon White, LCSW _____ Date: _____ / _____ /2018

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PRIMARY CARE PHYSICIAN

I, _____ hereby authorize Sharon Lynn White, SSJ, D. Min., LCSW
(PRINT NAME)

of 146 S. Lakeview Dr., Suite 300, Gibbsboro, NJ 08026 (856)784-2500 to disclose and to receive from
my primary care physician, _____ with offices located at
(PRIMARY CARE PHYSICIAN NAME)

(STREET ADDRESS, SUITE) (CITY, STATE, ZIP) (PHONE) (FAX)

and (if applicable) to disclose and to receive from my psychiatrist, _____
(PSYCHIATRIST NAME)

with offices located at _____
(STREET ADDRESS, SUITE) (CITY, STATE, ZIP) (PHONE)

all clinical/medical information about me as may be necessary to permit my **primary care physician, (and) (or) psychiatrist** to monitor the continuity of my care and to inform my primary care physician of my health status. I may refuse to release this information by initialing the “**refusal option**” which is located below to the right of my signature.

This authorization becomes effective _____, 2018 and may be revoked by me in writing at any time, except to the extent of action already taken. Unless earlier revoked by me, this authorization automatically terminates the earliest of six (6) months from the effective date, or the term of coverage of my benefit plan. I understand that this authorization does not extend to the release of any AIDS/HIV information unless I have also placed my initials here _____. I further understand that the information authorized by this Release will be released to the authorized recipient only, for the purpose noted above. I understand I (or my legal representative) am entitled to a copy of this authorization form for my records.

Refusal Option, Initial Here:

(LEGAL SIGNATURE OF CLIENT OR LEGAL GUARDIAN) _____ / ____ / 2018
(DATE)

(PRINT NAME OF CLIENT) _____ (WITNESS SIGNATURE) _____ / ____ / 2018
(DATE)

Notice to Recipient: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and/or state law. In accordance with federal and state law requirements, the information received pursuant to this document is confidential and recipient is prohibited from making further redisclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patients.

Sharon White, D.Min, LCSW
146 S. Lakeview Dr. Suite 300
Gibbsboro, NJ 08026
856-784-2500 Fax: 856-784-7700

Physician Communication Form

Physician/Provider: _____ Date: _____

Address: _____

Fax: _____ Phone: _____

Patient: _____ DOB: _____

I give permission for Sharon L. White, L.C.S.W. to provide and receive information from the above physician/provider.

Signature Date

OFFICE USE ONLY:

The above patient was recently seen in my office for mental health/substance abuse evaluation/treatment. I hope that this information will be helpful in coordinating this patient's care.

Date of Evaluation: _____ Most Recent Session: _____ Next visit: _____

Diagnosis: DSM V: _____

The patient reports the following medication/supplements: _____

Severity Indicators: No Yes: _____

Treatment Plan:

____ Individual Therapy ____ Couples Therapy ____ Family Therapy

____ Psychopharmacology Managed by _____

____ Referral to: _____

Medical History:

Smoker: No Yes Alcohol or other substances: No Yes _____

During my evaluation, the patient stated the following health concerns of which you may or may not be aware: _____

If you would like to discuss this further, please call me at 856-784-2500

Sharon L. White, L. C. S. W. _____ Date: _____

STRESS EXHAUSTION SYMPTOMS

NAME: _____ DATE: ____/____/2018

Check the symptoms of stress exhaustion you've noticed lately in yourself.

PHYSICAL

- ___ appetite change
- ___ headaches
- ___ tension
- ___ tired
- ___ unable to sleep
- ___ weight change
- ___ colds
- ___ muscle aches
- ___ stomach aches
- ___ racing heart
- ___ accident prone
- ___ teeth grinding
- ___ rashes
- ___ restlessness
- ___ foot tapping
- ___ increased alcohol, drug or tobacco use

EMOTIONAL

- ___ anxiety
- ___ frustration
- ___ the "blues"
- ___ mood swings
- ___ bad temper
- ___ nightmares
- ___ crying spells
- ___ irritability
- ___ "no one cares"
- ___ depression
- ___ nervous laugh
- ___ worrying
- ___ easily discouraged
- ___ little joy

SPIRITUAL

- ___ emptiness
- ___ loss of meaning
- ___ doubt
- ___ unforgiving
- ___ apathy
- ___ looking for magic
- ___ loss of direction
- ___ needing to prove self

MENTAL

- ___ forgetfulness
- ___ dull senses
- ___ poor concentration
- ___ spacing out
- ___ negative attitude
- ___ confusion
- ___ lethargy
- ___ racing mind
- ___ no new ideas
- ___ boredom
- ___ negative self talk

RELATIONAL

- ___ isolation
- ___ intolerance
- ___ resentment
- ___ lashing out
- ___ hiding
- ___ clamming up
- ___ loneliness
- ___ nagging
- ___ distrust
- ___ fewer contacts with friends
- ___ using people

CLIENT BACKGROUND

Name: _____ **Date:** ____/____/2018

Client's medical and psychological background
Please circle the applicable answer

- Do you tire easily? Yes No
- Do you get anxious easily? Yes No
- Do you get easily depressed or sad? Yes No
- Do you cry easily or often? Yes No
- Do you have difficulty remembering things? Often Yes No
- Do you tend to oversleep? Often Yes No
- Do you have difficulty sleeping? Often Yes No
- Do you wake up during the night? Often Yes No
- Do you have nightmares? Often Yes No
- Do you experience bed-wetting? Often Yes No
- Do you tend to overeat? Often Yes No
- Do you tend to under eat? Often Yes No
- Do you get frequent headaches? Yes No
If yes, how frequently? _____
- Do you drink more than 2 cups of coffee a day? Yes No
If yes, how many? _____
- Do you smoke cigarettes? Yes No
If yes, how many cigarettes a day? _____
- Have you **gained** or **lost** (circle) a significant amount of weight? Yes No
If yes, how much? _____
If yes, in what time period? _____
- Have you ever used illegal drugs? Yes No
If yes, when? _____
If yes, which drugs? _____
- Do you drink alcohol? Yes No
If yes, how often and how much? _____
- Is there a family history of drug or alcohol abuse? Yes No
If yes, by whom? _____
- When was your last physical exam? _____
- Do you have support systems? Yes No If yes, who and what relationship? _____
- Have you ever been in the military? Yes No What branch? _____ From (yr) _____ to (yr) _____

If you answer YES to any of the following questions, please elaborate on the back of this page.

- Do you have any serious medical problems and/or disability? Yes No
- Are you presently taking any medication? (List on the next sheet) Yes No
- Have you ever been hospitalized in a psychiatric setting? Yes No
- Have you ever been in therapy before? Yes No



PLEASE KEEP THE FOLLOWING NOTICE OF PRIVACY PRACTICES FOR YOUR RECORDS.

Sharon Lynn White, LCSW, LMFT
146 S. Lakeview Dr. Suite 300
Gibbsboro, NJ 08026
856-784-2500

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Sharon White, M.S.W 146 S. Lakeview Dr. Suite 300, Gibbsboro, NJ 08026 856-784-2500:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a “designated record set”. A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Sharon White, MSW, 146 S. Lakeview Dr. Suite 300, Gibbsboro, NJ 08026, 856-784-2500 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is January, 2018.