Gerson, Hagovsky, Antonelli & Altman LLC
22 Old Short Hills Road, Suite 216
Livingston, NJ 07039
(973) 994-3145
FAX: (973) 994-9152 Email: ghaa@ghaallc.com

Welcome to Gerson Hagovsky Antonelli & Altman, LLC. We are looking forward to working with you. We will make a reasonable effort to accommodate your needs. Please take the time to read the following information about our practice policies so that you may be fully informed about the services you are receiving. Please do not hesitate to ask questions if any of the following seems unclear. If you have any questions, please ask your therapist or doctor.

We would like you to be aware of your right to confidentiality and our commitment to safeguard that right. The patient-therapist relationship is a confidential and privileged one and is thus protected by law and ethical code. However, there may be limits to confidentiality depending on your circumstance. For example, if your health care carrier is under the Federal ERISA act, it is entitled to and may request information about your sessions. Likewise, PIP, Workers' Compensation, and other legal/court cases may override confidentiality. In cases in which there is a clear risk of harm to self or others or of suspected child abuse, confidentiality is limited by law. As healthcare professionals we may consult with others in an effort to enhance your treatment. We will request your prior consent beforehand.

If you participate in group, family, or couples therapy, we insist that you do not discuss the contents of those sessions with any person who is not a member of this practice or who is not a fellow client undergoing treatment with you in the same counseling sessions. Also, you must agree not to hold the Center or therapists responsible for any group/family couples therapy behavior. In the case of minors, it is important that parents/guardians understand the need of their children to develop trust in their therapists. Thus, we ask that parents/guardians limit their desire for specific details of the treatment. However, we will be sure to address any concerns parents may have regarding their child's treatment.

If you choose to engage in psychotherapy, please be aware that the process of psychotherapy involves change and can be an exciting process. At times, it may also seem frustrating and may arouse strong, difficult emotions. You may discover that the way you think about the world, the way you view your past, present, and future, and the way you relate to others may be altered. Therapy will require your work and commitment. Our most important mission as therapists is to help you make progress in your work toward reaching your goals. We will strive at all times to utilize our best clinical skills and professional judgment in this endeavor.

Individual and family therapy sessions are usually scheduled to last 45 minutes, unless otherwise indicated. We will make every effort to begin your session in a timely fashion. The frequency of therapy sessions is arranged by you and the therapists, based on the therapist's recommendations and your needs. You are free to terminate therapy at any time. Termination is usually a mutual goal that is planned for by the patient and therapist. If at any time you feel that therapy is not meeting your needs, you are strongly encouraged to present your concerns to the therapist.

Regarding billing, payment in full is due at the time the service is rendered unless other arrangements have been made. Information regarding fees is available upon request. We reserve the right to charge and interest of 1 1/2% per month (18% per annual percentage rate) on accounts that are greater than 30 days overdue. There is also a returned check fee. Please note that in cases in which the account has been neglected by the patient and there has been no show of good faith despite our repeated attempts towards resolution, we reserve the right to turn the account over to a collection agency. In hardship circumstances, we are available to discuss payment arrangements.

Our therapists may be available by telephone at times other than your scheduled appointment if there is a matter that cannot wait until the next session. For any telephone calls that last ten minutes or longer, we reserve the right to charge you a fee proportionate to the individual psychotherapy rate. If you have true emergency, and you call after regular business hours or cannot reach your therapist, please go to your local hospital emergency room immediately.

We reserve the right to charge you a $150 cancellation fee for any missed appointments or appointments that are canceled with less than 24 hours notice. This fee is the sole responsibility of the patient. An insurance claim will not be submitted for this $150 fee. In the case of a bona fide emergency, the charge may be waived.

We are not responsible for your insurance or health care coverage. We strongly encourage you to clarify the extent of any coverage with your carrier. Please be advised that what your insurance provider/representative says over the phone to either you or to our staff may not always be correct or clear. Our office staff can assist you with the information you may need to submit bills to your carrier. Ultimately, you are responsible for payment of the services rendered to you.

You may opt out of your insurance coverage. However, this request must be confirmed in writing.

After you have read this form, please sign your name and the date below indicating that you have understood and accepted what you have read. Thank you.

Signature of Patient if age 14 or over

PRINT PATIENT NAME

Signature of Parent or Sole Legal Guardian if Patient is under 18 years of age

Date

Signature of Other Parent if joint custody of Minor

Date

Gerson, Hagovsky, Antonelli & Altman, L.L.C
22 Old Short Hills Road, Suite 216
Livingston, NJ 07039
Phone: 973-994-3145 Fax: 973-994-9152 Email: ghaa@ghaallc.com

PATIENT INFORMATION

Patient Name: _____

Home Address: Street _____ **Apt**_____

City _____ **State**_____ **Zip Code**_____

Home Phone: _____ **Cell Phone:** _____

***Please advise the best number to leave a message:** _____

Email: _____**DOB:** _____ **Social Security:** _____

Marital Status: **( ) Married ( ) Single ( ) Divorced**

Insurance Company: _____

PLEASE INCLUDE COPY OF FRONT AND BACK OF INSURANCE CARD(s)

Insurance ID: _____ **Group Name/Number:** _____

Name of Insured: _____

Relationship to Insured: _____ **Insured Date of Birth:** _____

Insured Social Security: _____ **Employer:** _____

Address: _____

Deductible: _____ **Co-Pay:**_____ **Co-Insurance:**_____ **% allowed**_____

__ In-Network **____Out of Network**

Rendering Provider: _____ **Fee:** _____

Please read and sign below:

I understand the release of any medical or other information necessary to process insurance claims.

***Signature*:** _____ **Date:** _____

I authorize payment of medical benefits to the physician or supplier or services rendered.

***Signature*:** _____ **Date:** _____

Doctor:_____ **Fee:**_____

Referring Doctor:_____ **Date of Initial Visit**_____

DX Code (1):_____ **DX Code (2):**_____ **Individual___ Family___Couples___**

Gerson Hagovsky Antonelli & Altman, L.L.C.
22 Old Short Hills Road, Suite 216
Livingston, NJ 07039
(973) 994-3145
FAX: (973) 994-9152, Email: ghaa@ghaallc.com

New Patient Information Child

Name of Child_____ Sex: (M)__ (F)__

Birth Date: _____

Current Family Situation:

Mother's Relationship - Natural Parent ___Step Parent ___ Adoptive Parent ___Relative ___

Father's Relationship -Natural Parent ___Step Parent ___ Adoptive Parent ___ Relative ___

Marital History of Parents - Married ___ Separated ___ Divorced ___ Deceased Mother ___
Deceased Father ___

If adopted has the child been told? Yes ___ No ___

Living Arrangements:

Present Home - House ____ Apartment ___

Does the child share a room with anyone else? Yes ___ No ___

Has the child ever lived away from home? Yes ___ No ___

Family Source of Income: Mother ___ Father ___

Brothers and Sisters: (Indicate if step-brother or step-sister)

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Others Living At Home: _____

Name: _____

Health Information:
Health problems child has had of has now:_____

_____

Date and duration of any hospitalizations:_____

_____

Name and dosage of medications:_____

_____

Specialists seen now or previously (include psychiatrists, social workers, speech pathologists, etc.):

_____

_____

Developmental History:

Pregnancy - Full Term ___ Premature ___

Delivery problems: _____

Newborn problems (Colic, Weight Gain, Irritability, etc.) _____

Age when child walked - Typical ___ Delayed ___

Age when child talked - Typical ___ Delayed ___

Problems with bladder or bowel training: _____

Eating /Sleeping Patterns:
Number of meals per day and food preferences: _____

_____

Eating problems and issues: _____

_____

Food allergies: _____

Sleeping problems and issues: _____

Name: _____

Education History:
Schools attended and dates attended: _____

_____

_____

_____

Current grade average: _____

Academic Testing - Yes ___ No ___

Psychological Testing - Yes ___ No ___

Interests:
School subjects preferred: _____

Sports: _____

Hobbies: _____

Pets: _____

Number of Friends: _____

Current Problems: _____

_____

_____

Chief Complaint: _____

_____

How long has problem occurred? _____

Are there major family stressors? Financial ___ Marital ___ Health ___ Legal ___ Death___

Gerson, Hagovsky, Antonelli & Altman LLC
22 Old Short Hills Road, Suite 216
Livingston, NJ 07039
(973) 994-3145
FAX: (973) 994-9152 Email: ghaa@ghaallc.com

Credit/Debit Card Payment Consent

Client Name_____

(Card Holder) Name if different than client:_____

Card Type:_____

Credit Card Number: _____

CVV:_____

Expiration Date:_____

I authorize GHAA, LLC or its designated billing company to charge my credit card/debit/health account card for professional services 24 hours before scheduled appointment. If I do not cancel before 24 hours, I recognize that the office or designated billing company will charge my card at a late cancel fee of $150.00 or at the billing rate as negotiated.

I verify that my credit card information , provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent, or if my payment is declined, I understand that I am responsible for the ENTIRE amount owed and any interest or additional costs incurred if denied.

Clients Initals:_____ Card Holder Initials:_____
Date:_____

Signature:_____

Gerson Hagovsky Antonelli & Altman, L.L.C.
22 Old Short Hills Road, Suite 216
Livingston, NJ 07039
Phone: 973-994-3145 Fax: 973-994-9152 Email: ghaa@ghaallc.com

I _____, have reviewed the
(Patient's Name)

HIPAA - Health Insurance Portability and Accountability Act, Notice of Privacy Practice

provided by Dr. _____, on _____.
(Name) (Date)

I have read and understood the notice and have discussed any questions that I have with the doctor.

_____
(Signature of Patient/Parent or Guardian)

_____
(Date of Signature)

Gerson Hagovsky Antonelli & Altman, L.L.C.
22 Old Short Hills Road, Suite 216
Livingston, NJ 07039

HIPAA-The Health Insurance Portability and Accountability Act
Notice of Privacy Practice

The following information is being provided as required by Federal Law:
This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information.

I. Uses and Disclosures for Treatment, Payment and Health Care Operations

Your *protected health information* (PHI) may be used or disclosed 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 the provision, coordination or management of your healthcare and other services related to your health care. An example of treatment would be consultation with another health care provider, such as your family physician or another psychologist.
  -Payment refers to obtaining reimbursement for your health care. Disclosure of your PHI to your health insurer to obtain reimbursement for your healthcare or to determine eligibility for coverage are examples.
  -Health Care Operations are activities that relate to performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits, administrative services, case management and care coordination.
* "*Use*" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
* "*Disclosure*" applies to activities outside of my office, such as releasing, transferring or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

PHI may be used or disclosed 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 asked for information for purposes outside of treatment, payment and health care operations, an authorization will be obtained from you before releasing this information. An authorization will also be obtained before releasing your psychotherapy notes. "*Psychotherapy notes*" are notes made about our conversation during a private, group, joint or family counseling session, which have been kept 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) I have relied on the 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

Your PHI may be used or disclosed without your consent or authorization in the following circumstances:

* **Child Abuse**: If there is reasonable cause to believe that a child has been subject to abuse. I must report this immediately to the New Jersey Division of Child Protection and Permanency.

* **Adult and Domestic Abuse**: If there is reason to believe that a vulnerable adult is the subject of abuse, neglect or exploitation, I may report the information to the county adult protective services provider.

* **Health Oversight**: If the New Jersey State Board of Psychological Examiners issues a subpoena, I may be compelled to testify before the Board and produce your relevant records and papers.

* **Judicial or Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and must not be released without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I must inform you in advance if this is the case.

* **Serious Threat to Health or Safety**: If you communicate to me a threat of imminent serious physical violence against yourself or a readily identifiable victim and I believe you intend to carry out that threat, I must take steps to warn and protect. Such steps must also be taken if I believe you intend to carry out such violence, even if you have not made a specific verbal threat. The steps taken to warn and protect may include arranging for you to be admitted to a psychiatric unit of a hospital or other health care facility, advising the police of your threat and the identity of the intended victim, warning the intended victim or his or her parents if the intended victim is under 18, and warning your parents if you are under 18.

* **Worker's Compensation**: If you file a worker's compensation claim, release of relevant information from your mental health records to medical and non-medical experts in connection with the case, the Division of Worker's Compensation or the Compensation Rating and Inspection Bureau may be required.

IV. Patient's Right and Psychologist'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, I am not required to agree to a restriction you request.

* *Right to 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, I will discuss with you the details of the accounting process.

* *Right to Receive Confidential Communications by Alternative Means and at Alternate 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 me. Upon your request, I will send your bills to another address)

* *Patients can order their healthcare provider not to tell their healthcare insurer about services* - Out of pocket payments for mental health services may remain private at patient's request.

* *A provider cannot sell a patient's PHI without his or her explicit authorization* - If a patient's PHI accidentally goes public, the provider must notify him or her about the breach. Breaches are presumed reportable unless, after completing a risk analysis applying certain factors, it is determined that there is a low probability of PHI compromise.

* *Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in the mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I 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. I may deny your request. On your request, I will discuss with you the details of the amendment process.

* *Right to a Paper Copy* - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

* *Copies of e-PHI* - 30 days are allotted to respond to a patient's written request for his or her PHI, with one 30 day extension, regardless of where the records are kept. Access to HER (electronic health information) and other electronic records must be provided in the electronic form and

format requested by the individual if the records are readily reproducible in that format. Otherwise, the records must be provided in another mutually agreeable format. Hard copies are permitted only when the individual rejects all readily reproducible e-formats.

* *E-mailing* - Transmission security must be considered and PHI may be sent in unencrypted emails only if the requesting individual is advised of the risk and still requests that form of transmission.

* *Descendants* - Relevant disclosures to the deceased's family and friends may be made under essentially the same circumstances such disclosures were permitted when the patient was alive; that is, when these individuals expressed preference to the contrary. This rule eliminates any HIPAA protection for PHI 50 years after the patient's death.

Psychologists' Duties:

* I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

* I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

* If I revise my policies and procedures, I will inform you of the changes and provide you with the updated information in person or by mail.

V. Complaints

If you are concerned that your privacy rights have been violated, or you disagree with a decision made about access to your records, you may contact HIPAA Compliance Officer **Harold Altman, Ph.D.** at (973) 994-3145.

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.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice went into effect on *October 30, 2024*