A New Bloom Therapy, LLC
Laurel Oak Corporate Center
1010 Haddonfield Berlin Road
Suite 300
Voorhees, NJ 08043
(856) 469-1465

Consent for Treatment

The undersigned authorizes for myself and/or my child(ren) to receive counseling services from Jessica Friel, LCSW. I, as the custodial parent, have the right and authority to consent for treatment for and on behalf of my child(ren). (If legal guardianship or non-custodial parent, please provide court order and documentation authorizing such treatment.)

In signing this consent I am acknowledging that counseling requires a substantial part of my time and my therapist's time to work towards my therapeutic goals. I understand that I have the right to know the specifics of the treatment process and that I may ask questions about my treatment at any time. During counseling I agree to work with my therapist to improve my and/or my child (ren)'s social and psychological functioning.

I understand that the length of each session is 60 minutes and agree to arrive promptly for all scheduled appointments. I agree to provide at least 24 hours' notice if I need to cancel an appointment or I may be charged the full session fee for cancellation. I give permission to receive email or text message appointment reminders with the understanding that these are courtesy reminders only and the 24-hour cancellation agreement still applies.

Client Signature:_____ **Date:**_____

Parent/Guardian Signature:_____**Date:**_____

Therapist Signature:_____**Date:**_____

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FEE AGREEMENT

I understand that Jessica Friel, LCSW requires that the fee for each office visit be paid directly to her at the time of the session. Each 60-minute session will be $90.00.

I understand that I am financially responsible for all charges. Non-payment may result in suspension or termination of services until payments are made.

I understand that if a check is returned from the bank as “non-sufficient funds,” I will need to pay the session fee along with a $35.00 returned check fee prior to my next appointment. If I choose to pay with a credit card, a $5.00 convenience fee will be added.

I understand that I must give at least 24 hours’ notice if I need to cancel an appointment or the full session fee may be charged. If the cancellation is less than 24 hours and the appointment time can be filled, there will be no cancellation fee. Exceptions can be made in cases of illness or emergency at the discretion of the therapist.

By signing this document I am accepting the terms of this agreement.

Client Signature:_____ **Date:**_____

Parent/Guardian Signature:_____**Date:**_____

Therapist Signature:_____**Date:**_____

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Telehealth Informed Consent

- I understand that remote/virtual appointments involve the communication of medical/mental health information in an electronic or technology-assisted format.
- I understand that all electronic medical communications can carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:
    - It is easier for electronic communication to be intercepted or even changed without my knowledge and despite taking reasonable precautions.
    - Electronic systems that are accessed by anyone else other than the primary use are not secure and should be avoided. It is important to use a safe, secure network.
    - Despite reasonable efforts on the end of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.

- I understand that Zoom, FaceTime or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to conduct my therapy sessions in that manner.
- I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications. Jessica Friel is not responsible for breaches of confidentiality caused by an independent third party or by me.
- I understand that electronic communications cannot be used for emergencies or time-sensitive matters.
- I understand the inherent risks of errors or limitations in telehealth appointments.
- To the extent permitted by law, I agree to waive and release my therapist from any claims I may have about the telehealth visit.

Client Signature:_____ **Date:**_____

Parent/Guardian Signature:_____**Date:**_____

Therapist Signature:_____**Date:**_____

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IDENTIFYING INFORMATION:

Name:_____

Address:
Street:_____

City:_____State:_____Zip:_____

Phone:_____

Is it okay to text you on this number? Yes/No (please circle)
Is it okay to leave a voicemail on this number? Yes/No (please circle)

Age:_____ DOB:_____/_____/_____

Emergency contact: Name:_____Phone:_____

Referral Source:_____

What are the stressors in your life right now?

What is going well in your life right now?

What ways do you think therapy can be helpful for you?

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ADOLESCENTS:

Pre-Natal History (pregnancy issues, mother's use of medication:_____

Peri-Natal History (details of labor/delivery):_____

Developmental History (discuss milestones met early or late):_____

School information:

Name of school:

_____

Contact person (if applicable):

_____Phone:_____

Do you have an IEP? Yes_____ No_____

Do you have a 504 Plan? Yes _____No_____

If yes, please list accommodations:

Please list any school related concerns:

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ADOLESCENT INFORMATION CONTINUED:

	Yes	**No**	**Details**
Problems at school			
Problems at home			
Trauma			
Defying authority			
Stealing			
Destruction of property			
Fire setting			
Running away			
Legal involvement			
Eating disorder			
Sexually active			
Sexual orientation issues			

Please list any other issues/concerns:

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LIST ALL OTHER HOUSEHOLD MEMBERS:

Name	Age	Relationship to Client

CLIENT'S MEDICAL HISTORY:

Family Physician:_____Phone:_____

Address:_____

Medical Problems/Concerns:_____

Current Medications:_____

CLIENT'S PSYCHOLOGICAL HISTORY:

List previous therapists, hospitalizations, IOP Programs:

_____
_____
_____

List any previous psychiatric medications and reasons for stopping:

_____
_____

List any family history of mental health problems:

_____
_____

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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 Note of Privacy Practices describes how I may use and disclose your PHI in accordance with law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPPA 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.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required by law to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices.

HOW I 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 colleagues, and/or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

For Payment: I may use and disclose PHI so that I can assist you in receiving reimbursement payment for the treatment services provided to you. This will 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, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations: I may use or disclose, as needed, your PHI in order to support my business activities including, but not limited to, quality assessment activities, licensing, and conducting or arranging for other business activities. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law: Under the law, I must disclose your PHI to you upon your request. In addition, Imust make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my 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 me to disclose information about

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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 my practice to adhere to more stringent privacy requirements for disclosures without authorization. The following language addresses these categories to the extent consistent with NASW Code of Ethics and HIPAA.

Child Abuse or Neglect: I 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: I may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.
Deceased Patients: I 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: I may use or disclose your PHI ni a medical emergency situation to medical personnel only in order to prevent serious harm. I 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: I 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, I 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: I 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: I 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: I required, I 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.

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Public Safety: I may disclose your PHI if necessary to prevent or lessen a serious and imminent threat ot 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: I may send you fundraising communications at one time or another. You have the right ot opt out of such fundraising communications with each solicitation you receive.
Verbal Permission: I may 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 I 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; (il) 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 me.

- **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 record is are maintained electronically, you may aiso 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 me to amend the information although I am not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with me. I may prepare a rebuttal to your statement and will provide you with a copy. Please contact me 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 I make of your PHI. I 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. I am 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 plan or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.

- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about health matters in a certain way or at a certain location. I will accommodate reasonable requests. I 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. I 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, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right in a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing to me or with the Secretary of Health and Human Services at 20 Independence Avenue, S.W. Washington, DC. 20201 or by calling (202) 619-0257. I will not retaliate against you for filing a complaint.

The effective date of this Notice is February 19, 2025.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, have received a copy of Jessica Friel's Notice of Privacy Practices, Patient Rights and Grievance Procedures.

Client Signature:_____ **Date:**_____

Parent/Guardian Signature:_____**Date:**_____

Therapist Signature:_____**Date:**_____