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SECTION 1

Family Service Bureau of Newark

Newark Office: 274 South Orange Avenue, Newark, New Jersey 07103
Tel: 973-412-2056 Fax: 973-484-3452
West Hudson Office: 379 Kearny Avenue, Kearny, New Jersey 07032
Tel: 201-246-8077 Fax: 201-955-6165
www.newcommunity.org

Client Rights

As per *N.J. Admin. Code § 10:161B-16.2* - Each client receiving services shall have:

1. The right to be informed of these rights, as evidenced by the client's written acknowledgment or by documentation by staff in the clinical record that the client was offered a written copy of these rights and given a written or verbal explanation of these rights in terms the client could understand;

2. The right to be notified of any rules and policies the program has established governing client conduct in the facility;

3. The right to be informed of services available in the program, the names and professional status of the staff providing and/or responsible for the client's care, and fees and related charges, including the payment, fee, deposit, and refund policy of the program and any charges for services not covered by sources of third-party payment or the program's basic rate;

4. The right to be informed if the program has authorized other health care and educational institutions to participate in his or her treatment, the identity and function of these institutions, and to refuse to allow their participation in his or her treatment;

5. The right to receive from his or her physicians or clinical practitioner(s) an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risks(s) of treatment, and expected result(s), in terms that he or she understands;

> **i.** If, in the opinion of the medical director or director of substance abuse counseling, this information would be detrimental to the client's health, or if the client is not capable of understanding the information, the explanation shall be provided to a family member, legal guardian or significant other, as available;
>
> **ii.** Release of information to a family member, legal guardian or significant other, along with the reason for not informing the client directly, shall be documented in the client's clinical record; and
>
> **iii.** All consents to release information shall be signed by client or their parent, guardian or legally authorized representative;

6. The right to participate in the planning of his or her care and treatment, and to refuse medication and treatment;

> **i.** A client's refusal of medication or treatment shall be documented in the client's clinical record;

7. The right to participate in experimental research only when the client gives informed, written consent to such participation, or when a guardian or legally authorized representative gives such consent for an incompetent client in accordance with law, rule and regulation;

8. The right to voice grievances or recommend changes in policies and services to program staff, the governing authority, and/or outside representatives of his or her choice either individually or as group, free from restraint, interference, coercion, discrimination, or reprisal;

9. The right to be free from mental and physical abuse, exploitation, and from use of restraints;

> **i.** A client's ordered medications shall not be withheld for failure to comply with facility rules or procedures, unless the decision is made to terminate the client in accordance with this chapter; medications may only be withheld when the facility medical staff determines that such action is medically indicated;

10. The right to confidential treatment of information about the client;

> **i.** Information in the client's clinical record shall not be released to anyone outside the program without the client's written approval to release the information in accordance with Federal statutes and rules for the Confidentiality of Alcohol and Drug Abuse Client Records at *42 U.S.C. 290dd-2,* and 290ee-2, and 42 CFR Part 2 ??2.1 et seq., and the provisions of the Health Insurance Portability and Accountability Act (HIPAA) at 45 CFR Parts 160 and 164, unless the release of the information is required and permitted by law, a third-party payment contract, a peer review, or the information is needed by DHS for statutorily authorized purposes; and
>
> **ii.** The program may release data about the client for studies containing aggregated statistics only when the client's identity is protected and masked;

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11. The right to be treated with courtesy, consideration, respect, and with recognition of his or her dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy;

i. The client's privacy also shall be respected when program staff are discussing the client with others;

12. The right to exercise civil and religious liberties, including the right to independent personal decisions;

i. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any client;

13. The right to not be discriminated against because of age, race, religion, sex, nationality, sexual orientation, disability (including, but not limited to, blind, deaf, hard of hearing), or ability to pay; or to be deprived of any constitutional, civil, and/or legal rights.

i. Programs shall not discriminate against clients taking medications as prescribed;

14. The right to be transferred or discharged only for medical reasons, for the client's welfare, that of other clients or staff upon the written order of a physician or other licensed clinician, or for failure to pay required fees as agreed at time of admission (except as prohibited by sources of third-party payment);

i. Transfers and discharges, and the reasons therefore, shall be documented in the client's clinical record; and

ii. If a transfer or discharge on a non-emergency basis is planned by the outpatient substance use disorder treatment program, the client and his or her family shall be given at least 10 days advance notice of such transfer or discharge, except as otherwise provided for in *10:161B-6.4(c)*;

15. The right to be notified in writing, and to have the opportunity to appeal, an involuntary discharge; and

16. The right to have access to and obtain a copy of his or her clinical record, in accordance with the program's policies and procedures and applicable Federal and State laws and rules.

Client Signature_____Date_____

Staff Signature_____ Date_____

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Family Service Bureau (FSB) of Newark Intake Agreement/Consent for Services

Cancellation Policy:
It is the policy of the Family Service Bureau of Newark that you must give at least 24 hours of notice prior to your scheduled appointment of your intent to cancel/reschedule or be subject to a $25 late cancellation fee. Rescheduling appointments will be at the discretion of your therapist and Director. Please be advised that two cancellations and/or excessive rescheduling will be reviewed to determine if your termination of services is appropriate. Referrals to other services will be supplied to you upon termination.

No Show Policy:
An appointment no show will result in a $25 no show fee. No future appointments will be scheduled until the fee has been paid. After 10 business days of non-payment your case will be closed. Please be advised that two no shows will result in termination from the program. Referrals to other services will be supplied to you upon termination.

Medication Policy

FSB only provides medication services to individuals who are enrolled in and consistently receive psychotherapy services through FSB. You must receive weekly or bi-weekly psychotherapy to receive medication services.

Service Limitations and Length of Stay

If it is determined that you do not qualify for services under the program or you cannot be adequately treated by the program, you will be referred to another community program, agency or individual who can better address your needs. Please be advised that services at FSB are considered short-term. Treatment will complete on or before 18 months of service. Upon completion you will be referred to other services, if applicable.

Conflicts of Interest

Should a conflict of interest arise, you will be referred to another appropriate treatment source, up to and including referral to a different agency.

Medical Records

An electronic/paper record is maintained regarding your care and treatment. This documentation includes, but is not limited to, the following: a behavioral health assessment, progress notes and treatment plans.

Psychiatric Evaluations

Within your first 30 days at FSB you will be scheduled for a psychiatric evaluation. Please note that substance abuse clients will only be scheduled if deemed necessary by their assigned clinician. If you'd like to opt out of a psychiatric evaluation please notify the intake clinician at your intake appointment.

By signing below, I indicate that I have read, understand and agree to the terms of the intake agreement and consent of services.

Signature: _____ Date: _____

Staff Signature _____ Date: _____

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Appendix – Part 54a – Model Notice of Individuals Receiving Substance Abuse Services

Model Notice to Individuals Receiving Substance Abuse Services

No provider of substance abuse services receiving Federal funds from U.S. Substance Abuse and mental Health Services Administration, including this organization, may discriminate against you on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in religious practice.

If you object to the religious or non-religious character of this organization, Federal law gives you the right to a referral to another provider of substance abuse services. The referral, and your receipt pf alternative services, must occur within a reasonable period of time after you request them. The alternative provider must be accessible to you and have the capacity to provide substance abuse services. The services provided to you by the alternative provider must be of a value not less than the value of the services you would have received from this organization.

Your signature indicates that you were informed of the Federal charitable Choice Law.

Signature of Client:_____ Date: _____

Signature of Staff:_____ Date: _____

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I would like confidential HIV/AIDS testing? Yes _____ No

I have been offered a referral to, and list of rapid HIV counseling and testing sites.

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Rapid HIV Counseling and Testing Sites in Essex County

Newark Department of Health & Community Wellness
Communicable Diseases Prevention & Treatment Center
110 William Street
Newark, NJ 07102
973-648-2227

Newark Beth Israel Medical Center
Family Treatment Center
166 Lyons Avenue
Newark, NJ 07112
973-926-5197
973-926-8474

North Jersey AIDS Alliance (NJCRI)
393 Central Avenue
Newark, NJ 07102
973-483-3444 ext. 215

University Hospital
150 Bergen Street
Newark, NJ 07101
844-842-0756

St. Michael's Medical Center
306 Martin Luther King Jr. Blvd.
Newark, NJ 07102
973-877-5525

Planned Parenthood
240 Mulberry Street
Newark, NJ 07102
973-622-3900

Satellite Sites of Newark Community Health Center
973-565-0355
800-994-6242

East Orange Department of Health
143 New Street
East Orange, NJ 07017
973-266-5454

Rapid HIV Counseling and Testing Sites in Hudson County

Jersey City Medical Center
355 Grand Street

Catholic Charities of Archdiocese of Newark

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Jersey City, NJ 7305
Facility
201-204-0004

Hudson County Correctional

35 Hackensack Avenue
Kearney, NJ 7032
908-497-3900

To view additional testing sites visit https://nj.gov/health/hivstdtb/servicemap.shtml
Or call: 609-984-6328

I have been offered a referral and a listing of local sites for PPD testing (tuberculosis).

Below you will find a listing of local facilities that offer free testing and follow up if necessary.

_____ _____

Client Signature Date

_____ _____

Staff Signature Date

PPD Testing Sites

Newark Department of Health Wellness
Communicable Diseases Prevention & Treatment Center
110 William Street
Newark, NJ 07102
973-648-2227

Irvington Health Center & Community
1150 Springfield Ave.
Irvington, NJ 07111
973-399-6292

East Orange Department of Health & Human Services
143 New Street
East Orange, NJ 07017
973-266-5454

Orange Health Department
29 N. Day Street
Orange, NJ 07050
973-266-4068

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Christ Hospital, Jersey City, NJ
176 Palisade Ave,
Jersey City, NJ 07306
(201)795-8200

Jersey City Medical Center
355 Grand St,
Jersey City, NJ 07302
(201)915-2000

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www.newcommunity.org

Please Circle One

Referral for Physical Exam

This is to serve as an acknowledgment that I have received a referral for a Physical Exam.

In the event I do not have a preferred medical professional where I can seek a physical examination. I acknowledge to have been made aware that I can obtain a Physical Examination at the following community provider:

Essex County

University Hospital
150 Bergen Street
Newark, NJ 07101
973-973-4300

Hudson County

Jersey City Medical Center
355 Grand Street
Jersey City, NJ 07305
201-915-2000

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

To view additional testing sites, visit https://nj.gov/health/hivstdtb/servicemap.shtml. Or call: 609-984-6328

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Disclosure Regarding Provision of Counseling Services

Patient Name: _____

In accordance with the New Jersey Office of the Attorney General, Division of Consumer Affairs State Board of Marriage and Family Examiners Alcohol and Drug Counselor Committee and Professional Counselor Committee (Herein after referred to as "the state licensed body") Statutes and Regulations, Family Service Bureau of Newark has advised me of the following:

In accordance with Regulation N.J.A.C. 3:34 C-6.2(c), N.J.A.C. 13:34-13.1(g) and N.J.A.C. 13:34-3.3 (b), I understand that I may receive counseling services from a clinician who is not a (Licensed) Certified Alcohol and Drug Counselor (L)CADC, Licensed Professional Counselor or Licensed Marriage and Family Therapist; however, this individual shall remain under the clinical supervision of an appropriately licensed/certified supervisor as per Regulation N.J.A.C. 3:34 C-6.2(c), N.J.A.C. 13:34-13.1(g) and N.J.A.C. 13:34-3.3 (b).

Signature of Client:_____ Date: _____

Signature of Staff:_____ Date: _____

An original copy of this form will be placed in client's file.

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Advanced Directive

On January 11th, 1992, a New Jersey law took effect, which mandates that all health care facilities ask patients whether they have an Advanced Directive or Living Will. At Family Service Bureau of Newark, we have made this part of the admission process.

If you have an Advanced Directive, please bring it to Family Service Bureau upon your next visit.

If you do NOT have an Advanced Directive, please read the following information. An Advanced Directive is a document which allows you to give written instructions to those caring for you indicating the type of health care you wish to receive or reject in the event that you become unable to express these decisions yourself. There are three (3) different types of Advanced Directive:

1. *Proxy Directive*
   This is a document in which a competent adult names a trusted relative or, friend to make health care decisions on their behalf when they are unable to make these decisions.

2. *Instructive Directive*
   In this document, the person writing provides written instructions concerning the type of medical treatment they want performed for them and under what circumstances.

3. *Combined Directive*
   In this document, a competent adult states their general wishes regarding the kind of health care they wish to receive but appoints a trusted relative or friend to carry them out.

A brochure containing Living Will information is available from the Division of Aging. If you wish to receive this brochure, please make your request to:

The Division of Aging, 101 South Broad Street, CN807, Trenton, New Jersey 08625

Do you have an Advanced Directive? _____ Yes _____ No

If yes, please bring a copy to Family Service Bureau on your next visit.

Client Signature: _____ Date: _____

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Name: _____ Date: _____

I would like the following family/friends involved in the treatment:

Name: _____

Address: _____

_____

Telephone: _____

_____ At this time I do not wish to have family/friends involved in my treatment. However, I do understand the potential benefits that increased support from family/friends could have on successful treatment outcomes. I may consider family involvement in the future.

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Please initial one of the following statements:

_____ I consent

_____ I do NOT consent

to allow Family Service Bureau of Newark, permission to send me a Follow-up Discharge Letter/Survey.

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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Safe & Drug Service Agreement

Family Service Bureau is committed to providing services in a safe and drug-free environment. For everyone's safety, any person suspected of being impaired or under the influence of any substances will not be seen at that time and another appointment will need to be scheduled.

Family Service Bureau recognizes the tremendous toll that substances take on the person who suffers from addictive disorders and their families. We are fully committed to providing a safe place for those who wish to address substance issues — to speak in full confidence. Use of substances does NOT preclude anyone from receiving services at this Agency. All our services are in full compliance with HIPPA and Federal Confidentiality laws — 42: CFR part 2.

Policy:

Any person suspected of being "*impaired*" or "*under the influence*" of any mind or mood altering substances will be asked to contact a family member or friend to escort them from the premises to insure that they arrive home safely. If no one is available to provide transportation or escort, a cab will be called *at the expense of the client*.

A suspicion of "*impaired*" or "*under the influence*" means that the clinician or any staff member can visibly see that the client is having difficulty with gross motor movement or can smell substance use (alcohol or other substance).

No person will be permitted entry into "group", nor will the staff member be able to provide services at this time. Any person who presents with significant impairment, will be treated as a medical emergency and an ambulance will be called to take him/her to the local Emergency Room.

I have read the Safe & Drug-Free Services Agreement and have had the opportunity to discuss with my counselor. I understand, and agree to abide by this policy

Name: _____

Signature: _____ Date: _____

Staff: _____ Date: _____

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Rev. 8-27-19

Client's Name: _____ D.O.B. _____/_____/

Address: _____
Street City State Zip

CONSENT TO OBTAIN/RELEASE INFORMATION

I authorize (FSB Therapist) _____ to correspond with:

Person/Agency: _____

Address: _____

Phone: _____

To OBTAIN the following information and/or RELEASE the following information: Please initial where applicable

- ____ Psychosocial Evaluation
- ____ Intake/Admission Summary
- ____ Treatment Progress
- ____ Probation/Parole Records
- ____ Child Study Team Evaluations
- ____ Drug Screen Results
- ____ Psychiatric/Psychological Records
- ____ Treatment Plans/Recommendations
- ____ Closing/Discharge Summary
- ____ School Records
- ____ Medical Records
- ____ Other: _____

For the purpose of: _____

I voluntarily choose to sign for the purpose(s) specified above. **This release will expire in 1 year of date signed unless otherwise specified.** I further understand that I may cancel authorization for release of information at any time unless the information has already been sent. Unless otherwise specified any permission to release the above information will expire within 4 weeks following conclusion of treatment.

_____ _____
Client Signature Date:

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Staff Signature Date

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Client's Name: _____ D.O.B.:_____

Address: _____
Street City State Zip

CONSENT TO OBTAIN/RELEASE INFORMATION

I,_____ , authorize Family Service Bureau of Newark, Rutgers University Behavioral Health Care (UBHC) in the capacity of the Interim Management Entity (IME) and . the New Jersey Department of Human Services/Division of Mental Health and Addiction Services (NJ DHS/DMHAS) to communicate with and disclose to one another information about my substance use treatment.

The purpose of the authorized disclosure is to enable (Provider Agency), UBHC in the capacity of the IME and the NJ DHS/DMHAS to provide me with better, more coordinated treatment and allow for the evaluation and authorization of my treatment. I understand that the information available to these entities will be exchanged verbally and electronically through the New Jersey Substance Abuse Monitoring System (NJSAMS), a secure computer system, and my information will be maintained in the NJSAMS.

I understand that my medical records are protected under federal and state law, including the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that I may be denied services if I refuse to consent to disclosure for the purpose of treatment, payment, or health care operations. I will not be denied services if I refuse to consent to disclosure for other purposes.

DESCRIPTION OF INFORMATION TO BE DISCLOSED/RELEASED:

All my health information, including my drug and/ or alcohol treatment record and records about other conditions, including medical and mental health conditions, for which I might have received treatment.

TERM/EXPIRATION/REVOCATION

This signed consent will expire one year from today and will remain in effect until that date. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it.

_____ _____
Client Signature Date

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Staff Signature Date

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Family Service Bureau of Newark

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 it carefully.

Family Service Bureau of Newark is providing this Notice of Privacy Practices because the privacy of your health information is very important to you and to us, and in compliance with federal regulations.

By "your health information" we mean the information that we maintain that specifically identifies you and your health status.

Summary

This Notice describes how we use your health information within Family Service Bureau and disclose it outside Family Service Bureau, and why.

This Notice covers:

- Uses or disclosures that do not require your written authorization.
    - Treatment, payment, and health care operations.
    - Uses or disclosures of your health information to which you may object.
    - Uses or disclosures required or permitted.
- Uses or disclosures that require your written authorization.
- Your rights as a patent regarding privacy of your health information.
- Our duties in protecting your health information.
- Complaints, contact person, effective date, and acknowledgement.

USES OR DISCLOSURES THAT DO NOT REQUIRE YOUR WRITTEN AUTHORIZATION

Treatment, Payment, and Health Care Operations

We use or disclose your health information to carry out your treatment; to obtain payment for your treatment; and to conduct health care operations. For example:

- For treatment, we use your health information to plan. Coordinate, and provide your care. We disclose your health information for treatment purposes to physicians and other health care professionals outside our agency who are involved in your care.
- For payment, we use your health information to prepare documentation required by your insurance company or HMO or by Medicare or Medicaid. We disclose that part of your health information that these organizations require to pay us.
- For health care operations, we use or disclose your health information, for example, to improve the quality of our services, to plan better ways of treating patients, and to evaluate staff performance.

Uses or Disclosures of Your Health Information to Which You May Object

We may use or disclose your health information for the following purposes, unless you ask us not to.

- Informing family and friends. We may disclose your health information to family, friends, or others identified by you who are involved in your care with a signed consent from you.
- Assistance in disaster relief efforts.

- For fundraising activities. We may contact you or your family for fundraising purposes. If you do not wish to be contacted for this purpose, please contact and indicate that you do not wish to receive fundraising communication from us.
- Confirming your appointments.
- Informing you about treatment alternatives or other health related benefits and services that may be of interest to you.

If you object to our use of your health information for any of these purposes please contact:

Privacy Officer
Family Service Bureau of Newark
973-412-2056

Uses or Disclosures Required or Permitted

Where we are required or permitted to do so, we may use or disclose your health information in the following circumstances without your written authorization.

- If a consumer voices a threat against a specific individual or group, that individual or person responsible for the group (e.g. school principle if the threat was made against a school) must be notified. Police may be notified if the intended victim cannot be notified. [practitioners have a duty to warn],
- If a consumer reveals that child abuse may have taken place, the Division of Child Protection and Permanency must be notified [10:37-6.108(b)]
- If the consumer is a minor suspected of being abused, the record may be released to DCPNP [10:37-6.79(c)]
- If a consumer reveals abuse on a rooming/boarding/nursing home, this shall be reported to the County Welfare Agency [10:37-6.108(b)],
- Information may be shared with another mental health agency in accordance with HIPAA [10:37-6.79 (b)1i]
- If a judge orders the release of information to a court [10:37-6.79(a)2],
- If a consumer is psychiatrically evaluated by a psychiatric screening center, information may be released to the screening staff to facilitate the evaluation [10.37-6.79(a)3]
- To comply with any Federal or State law requiring the release of information [10.37-6.79(a)3]
- When the Office of Licensing or Medicaid conducts a review, a consumer's clinical record may be reviewed [10.37-6.79(b)2]
- An accreditation reviewer may look at a consumer's record [10:37-6.79(b)3]
- If officials within the offices of the State Medical Examiner or a County Medical Examiner making investigations and conducting autopsies request the information [10:37-6.79(b)4]
- Non-specific information may be provided to a family member or friend if the consumer does not object [N.J.A.C. 10:37-6.79(e)];
- To a consumer's personal physician to benefit the consumer [N.J.A.C 10:37-6.79 (f)]
- Medication information may be released to the consumer's pharmacy under the age of 18 requiring authorization will be determined by the consumer's parent or guardian [N.J.A.C. 10:37-6.79(a)1ii(2)]

Uses or Disclosures Which Require Your Written Authorization

Your written authorization, which you may revoke (in writing), is required if we use or disclose your health information for any purpose other than those stated above. In particular your authorization is required if:

- We use or disclose your psychotherapy notes other than for treatment or health care operations s specified in federal regulations.
- We use or disclose your health information for marketing or goods or services.

Your Rights As A Patient To Privacy Of Your Health Information

- **Right to Request Restrictions**

You have the right to request restrictions on out uses and disclosures of your health information, however we may refuse to accept the restriction.

- **Right to request an Accounting of Disclosures of Your Health Information**
  You have the right to request an accounting of our disclosures of your health information for purposes other than treatment, payment, and health care operations. We will make every attempt to honor your request. We are not required to provide n accounting for disclosures before April 13, 2003 or for more than 6 years prior to the date of your request.
- **Right to Obtain a Paper Copy of this Notice**
  If you have received this Notice electronically, you have the right to receive a paper copy. To exercise any of these rights please write or telephone our offices at 274 South Orange Avenue Newark, NJ 07103, (973) 412-2056 or 379 Kearny Avenue Kearny, NJ 07032, (201) 246-8077.

Our Duties in Protecting Your Health Information

- We are required by law to maintain the privacy of your health information
- We must inform our patients or their legal representatives of our legal duties and privacy practices with respect to health information. This notice discharges that duty.
- We must abide by the terms of the Notice currently in effect.
- We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that we maintain. At any time, you may obtain a copy of the current notice from our Privacy Officer, or the person designated by said officer.

Complaint, Contact Person, Effective Date, and Acknowledgement

- You may complain to us and to the Secretary of Health and Human Services if you believe your rights have been violated.
- You will not be retaliated against for filing a complaint.
- You may file your complaint with our agency by writing to our Privacy Officer at 274 **South Orange Avenue Newark, NJ 07103** or calling **(973) 412-2056.**
- You may file a complaint with the Secretary of Health and Human Service by writing to:
  Secretary of Health and Human Services
  U.S. Department of Heath and Human Services
  200 Independence Avenue S.W.
  Washington, D.C. 20201
  (source *www.hhs.gov*)
- For further information you may write or call our Privacy Officer at:
  274 South Orange Avenue, Newark, NJ 07103 or by calling **(973) 412-2056.**
- This notice is effective April 14, 2003.

Family Service Bureau of Newark
Newark Office: 274 South Orange Avenue, Newark, New Jersey 07103
Tel: 973-412-2056 Fax: 973-484-3452
West Hudson Office: 379 Kearny Avenue, Kearny, New Jersey 07032
Tel: 201-246-8077 Fax: 201-955-6165
www.newcommunity.org

Notice of Privacy Practices

Acknowledgment of Receipt of Notice

Client Name: _____ DOB: _____

A copy of the Family Service Bureau's Notice of Privacy Practices has been given to me.

Signature: _____ Date: _____/_____/_____

If personal representative:

Name: _____

Relationship to Client: _____

Reason signature not obtained:

( ) Client too sick at this time
( ) Client would not sign
( ) Other: _____

Name of Family Service Bureau employee attempting unsuccessfully to obtain signatures:

Employee Name: _____ Date: _____/_____/_____

Notice of Child Care Policy

A copy of the Family Service Bureau's Child Care Policy has been given to me.

Signature: _____ Date: _____/_____/_____

If personal representative:

Name: _____

Relationship to Client: _____

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GRIEVANCE, COMPLAINT, SUGGESTION Policy & Procedure

If you are unhappy with the services that you have received at the Family Service Bureau of Newark, you are entitled to a fair hearing with a staff member so that your complaint can be resolved to your satisfaction. If you have spoken with the staff person and feel that you cannot resolve the problem, you can speak to the supervisor. If your problem is still not resolved, then you can begin more formal complaint proceedings. Upon intake at FSB, clients are given Statewide advocacy services available to them [N.J.A.C. 10:37-4.6(b) 1]; however, if this is internal the grievance process at FSB is as follows:

1. Notify the staff person that you wish to file a complaint or grievance.
2. Staff will immediately notify the Clinical Supervisor.
3. The Program Director will notify the Agency Ombudsperson.
4. The Agency Ombudsperson will receive the complaint and act as your advocate. This person will attempt to negotiate a resolution of the issues within five (5) working days of receipt of the complaint.
5. If you feel that your complaint still has not been resolved, your complaint will be forwarded to the Executive Director of the Family Service Bureau of Newark. for review and resolution. The Executive Director will make the final resolution for the agency within seven (7) working days of receiving the complaint.
6. If you continue to be dissatisfied you can request a review from the County Mental Health Board. The Executive Director will notify the Mental Health Board Administrator within five (5) working days.
7. The County Mental Health Board will review your compliant and will inform the Executive Director of its recommendations within seven (7) working days.
8. If you remain unsatisfied, you may request a review by the New Jersey Division of Mental Health and Addiction Services.
9. These actions will not result in retaliation or barriers to services in anyway.

At anytime during this process, you may contact an outside agency.

I have read and understand the Grievance Procedures. I have received a Grievance Procedure List for Essex County.

Client Signature Date

Staff Signature Date

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CLIENT ADVOCACY RESOURCES

Resources	Phone Number
Community Mental Health Law Project ***Bloomfield@chlp.org***	**973-680-5599 or 973-275-1175** ***650 Bloomfield Avenue, Suite 210*** ***Bloomfield, New Jersey 07003***
Community Mental Health Administrator(s) ***Essex:*** ***Hudson County:***	**973- 571-2821 or fax 973 -571- 2820** ***Joseph Scarpelli, Administrator*** ***Essex County Department of Health*** ***204 Grove Avenue, Cedar Grove, NJ 07009*** ***Jscarpelli@helath.essexcountynj.org*** ***Robin F. James, MA*** ***Dept. of Health & Human Services*** ***830 Bergen Ave, 2B*** ***Jersey City, NJ 07306*** ***Phone: (201) 369-5280, ext. 4250*** ***E-mail: rjames@hcnj.us***
Adult Protective Services **Essex County:** **Focus, *Hispanic Center for Human Development Inc.*** ***441-443 Broad Street*** ***Newark, New Jersey 07102*** ***Hudson County Adult Protective Services*** ***6100 Adams Street*** ***West New York, NJ 07903***	**866-903-6287** ***After hours: 911 or local police*** **201-537-5631** ***After hours: 911 or local police***
Disability Rights New Jersey ***210 South Broad St. 3rd Flr.*** ***Trenton, NJ 08608*** ***www.drnj.org***	**800-922-7233**
Division of Mental Health and Addiction Services **Special Assistant for Consumer Affairs** **Margaret Molnar** **5 Commerce Way** **Hamilton, NJ**	**609-438-4338**
Division of Mental Health Advocacy **State of New Jersey** **Richard J. Hughes Justice Complex** **25 Market Street** **Trenton, NJ 08626**	**877-285-2844**

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Division of Child Protection and Permanency **(formerly Division of Youth and Family Services)** **(Essex County Office – DCP&P)** ***153 Halsey Street, Newark, NJ 07101*** ***(Hudson County Office- DCP&P)*** ***Jersey City, NJ 07306*** ***438 Summit Avenue, 4th Floor*** ***Jersey City, NJ 07306***	**973- 648-4200** **1-800-392-9532** **201- 795-0423 (Hudson)**
Essex County Welfare Agency ***Essex County Dept. of Citizen Services Division of Welfare*** ***18 Rector Street, 9th fl.,*** ***Newark, NJ 07102*** ***Hudson County Welfare Agency*** ***Hudson County Department of Family Services 257 Corenelison Ave.*** ***Jersey City, NJ 07302***	**973- 733- 3000** **201-420-3000**
Division of Mental Health and Addiction Services ***Northern Regional Office*** ***100 Hamilton Plaza, Box 4*** ***Paterson, NJ 07505***	**973-977-4397 or 1-800-382-6717**
Protection & Advocacy of New Jersey **(formerly Public Advocate's Office)** ***advocate@njpanda.org***	**800-922-7233 (statewide)** **609 -292 -9742** ***NJ Protection and Advocacy, Inc.*** ***210 So. Broad Street, 3rd fl.,*** ***Trenton, NJ 08608***
Legal Services of New Jersey ***5 Commerce St.*** ***Newark, NJ 07102***	**973- 624-4500**
NAMI-New Jersey ***1562 Route 130*** ***North Brunswick, NJ 08902*** ***www.naminj.org***	**732-940-0991** **Email- info@nami,org**
New Jersey Self –Help Group Clearinghouse ***673 Morris Ave. Suite 100*** ***Springfield, New Jersey 07081***	**800-367-6274**
Child Abuse/Neglect Hotline	**1- 877-652-2873**

Ref:NJAC 10:37 -4.6 (b) 1 Last Update 9/15/2017

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Consent for Substance Abuse Screening

I, _____ , consent to random drug and alcohol screening while participating in treatment at Gateway to Freedom. I have been made aware of the following:

1. All positive results will be reported to probation and/or parole or other collateral source monitoring treatment.

2. Any diluted/adulterated urine drug screens will be deemed as positive and will be reported to probation and/or parole or other collateral source monitoring treatment.

3. Failure to submit a screen will be deemed positive and will be reported to probation and/or parole or other collateral source monitoring treatment.

4. If requested to come in for a screen on days when I am not scheduled for treatment or on days that I am absent from treatment, failure to provide a specimen under this request will also be considered a positive and reported to the monitoring agencies (i.e. drug court, parole, DCPP, SAI etc.)

Client: _____ Date: _____

Staff: _____ Date: _____

Monitoring Office/Caseworker: _____

Phone Number: _____

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Gateway to Freedom Program and Group Rules

Please note the following rules have been implemented to assure consistency and equality for all participants within G2F Program.

1. There is a 15 minute grace period**. Anyone arriving after 15 minutes will be considered late and marked as absent.**
2. All participants are expected to follow their schedule. If you will be absent or late, **YOU** must inform your officer, if applicable, as well as inform the Program prior to the start of group.
3. Upon return from an absence, **YOU MUST** provide a urine sample prior to re-starting treatment.
4. Arrange all outside appointments on your scheduled days off.
5. **No drugs or Alcohol are allowed on the premises. (Immediate termination and reported back to your referral source)**
6. All cellular devices must be turned off and kept in pocket during treatment hours. **(See your counselor regarding emergencies)**
7. **Random urines will be collected upon staff request.** If the client is unable to provide a sample prior to departure, his file will reflect a refusal and documented as a **POSITIVE** result. **Clients may be asked to provide a daily sample.**

Group Rules

1. No cross talking.
2. No leaving of group without permission.
3. Respect each other and staff.
4. Make a concerted effort to participate in the group discussion.
5. The group information is confidential. **What is said in group stays in group!!!**
6. No sleeping in group.

Consequences First incident – Verbal warning

- **Second incident –** Asked to leave and contact your referral source
- **Third incident –** Discharge from G2F and contact your referral source

Client Signature_____ Date _____

Staff Signature _____ Date _____

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Office Policies and Privacy Notice

Length and nature of Appointments
During your first visit, you will be asked about your reasons for seeking mental health / psychiatric or substance abuse treatment and your goals for the future. After the initial visit, your appointments will last between 30 and 45 minutes depending on the nature of your treatment. At the end of the initial consultation appointment, your clinician provides a clinical diagnosis and treatment recommendations. Subsequent appointments are scheduled at a frequency determined to be appropriate to the clinical issues at hand. A commitment to regular follow-up appointments is essential in order to monitor clinical response to treatment and to optimize outcome.

Late or Missed Appointments
Each appointment is scheduled to begin and end on time. Please contact your clinician with at least 24 hours workday notice to cancel an appointment or the full. Please keep in mind that missed appointments disrupt your progress in treatment.

Phone Calls
Non-urgent clinical issues should be discussed at appointments. Telephone calls to your clinician should only be made for urgent matters that cannot wait until the next appointment. Please do not email or text about clinical matters,

Medications and Refills
Inform all of your doctors about all of your medications and any new medical problems. Prescriptions are not called in lieu of an appointment. Prescription refills are given at regular appointments. Requests for prescription refills by telephone will be granted only for patients being seen regularly.

Privacy Notice
By accepting services from Family Service Bureau of Newark, you are agreeing to the HIPAA NOTICE OF PRIVACY PRACTICES.

HIPAA Notice of Privacy Practices – Effective Date: March 23, 2020

This notice describes how health / medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact Family Service Bureau of Newark.
This notice describes the privacy practices at our office.
We are required by law to:

- Maintain the privacy pf protected health information.
- Give you this notice of our legal duties and privacy practices regarding your health information.
- Follow the terms of the notice currently in effect.

How Family Service Bureau of Newark, may Use and Disclose your Health Information
Described as follows are the ways we may use and disclose your health information. Except for

the following purposes we will use and disclose your health information only with your written permission. You may revoke such permission at any time by writing to Family Service Bureau of Newark.

Treatment
Family Service Bureau of Newark, may use and disclose your health information for your treatment and to provide you with treatment-related health care services. For example, we may disclose your health information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your health / medical care and need the information to provide you with health /medical care.

Payment
Family Service Bureau of Newark, may use and disclose your health information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give information to your health plan so that they will pay for your treatment.

Health Care Operations
Family Service Bureau of Newark, may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services.
Family Service Bureau of Newark, may use and disclose your health information to contact you and remind you of your appointment, to tell you about treatment alternatives or health-related benefits and services you could use.
Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share your health information with a person involved in, or paying for, your care (such as your family or a close friend). Family Service Bureau of Newark, may notify your family about your location or condition or disclose such information to an entity assisting in disaster relief.

Research
Family Service Bureau of Newark, may use and disclose your health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we do so, the project needs to go through a special approval process. Even without special approval, we may permit researchers to look at records to help identify patients who may be included in their research, as long as they do not remove or copy any of your health information.
As required by Law, Family Service Bureau of Newark, will disclose your health information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety
Family Service Bureau of Newark, may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. Disclosures will be made only to someone who can prevent the threat.

Business Associates
Family Service Bureau of Newark, may disclose your health information to our business associates that perform functions on our behalf or provide us with services if necessary. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose the information for any other purpose than appears in their contract with us.

Military and Veterans
If you are a member of the armed forces, Family Service Bureau of Newark, may release your health information as required by military command authorities. If you are a member of a foreign military, Family Service Bureau of Newark, may release your health information to the foreign military command authority.

Worker's Compensation
Family Service Bureau of Newark, may release your health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks
Family Service Bureau of Newark, may disclose your health information for public health activities to prevent or control disease, injury or disability. Family Service Bureau of Newark, may use your health information in reporting births or deaths, suspected child abuse or neglect, medication reactions or product malfunctions or injuries, and product recall notifications. We may use your health information to notify someone who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. If we are concerned that a patient may have been a victim of abuse, neglect, or domestic violence we may ask your permission to make a disclosure to an appropriate government authority. Family Service Bureau of Newark, will make that disclosure only when you agree or when required or authorized to do so by law.

Health Oversight Activities
Family Service Bureau of Newark, may disclose your health information to a health oversight agency for activities authorized by law. These may include audits, investigations, inspections, and licensure. These activities are necessary to for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or dispute, we may disclose your health information in response to a court or administrative order. Family Service Bureau of Newark, may disclose your health information in response to a subpoena, discovery request, or other lawful process by someone

else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
Family Service Bureau of Newark, may release your health information request by law enforcement official if 1) there is a court order, subpoena, warrant, summons or similar process; 2) if the request is limited to information needed to identify or locate a suspect, fugitive, material witness, or missing person; 3) the information is about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain your agreement; 4) the information is about a death that may be the result of criminal conduct; 5) the information is relevant to criminal conduct on our premises; and 6) it is needed in an emergency to report a crime, the location of a crime or victims, or the identity, description, or location of the person who may have committed the crime.
Coroners, Medical Examiners, and Funeral Directors. Family Service Bureau of Newark, may release your health information to a coroner, medical examiner, or funeral director to identify a deceased person or cause of death, or other similar circumstance.
National Security and Intelligence Activities. We may disclose your health information to authorized federal officials for intelligence and other national security activities authorized by law.
Inmates or Individuals in Custody. If you are an inmate of a correctional institution or in custody, we may disclose your information 1) for the institution to provide you with health care, 2) to protect your health and safety or that of others, and 3) for the safety and security of the institution.

Your Rights Regarding Your Health Information

Right to Inspect and Copy
You have the right to inspect and copy your medical and billing records by written request to Family Service Bureau of Newark.

Right to Amend
You have the right to request an amendment to your records by written request to Family Service Bureau of Newark.

Right to an Accounting of Disclosures
You have a right to an accounting of certain disclosures by written request to Family Service Bureau of Newark.

Right to Request Restrictions
You have the right to request restriction or limitation on your health information used for treatment, payment or health care operations. You may request Family Service Bureau of Newark to limit disclosure to someone involved in your care or in payment for your care (such as a spouse) by written request to Family Service Bureau of Newark. Family Service Bureau of Newark is not required to agree with your request, but we will try to comply.

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Right to Request Confidential Communication

You have the right to request that Family Service Bureau of Newark, communicate with you about medical matters in a certain way or at a certain location. You can ask, for example, that we contact you only by mail or at work. Your written request must specify how or where you wish to be contacted and be addressed to Family Service Bureau of Newark, we will accommodate reasonable requests.

Changes to this Notice

Family Service Bureau of Newark may change this notice and make it effective for medical information Family Service Bureau of Newark already has about you as well as new information. The current notice will be posted and available at all times. You have a right to request a paper copy of the current notice at any visit or by written request to Family Service Bureau of Newark.

1. Signature: _____
2. Name (Print): _____
3. Date: _____
4. Address: _____

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Telehealth Contract and Informed Consent

Introduction Sessions and visits will be held using video conferencing through a HIPAA compliant platform. Telehealth establishes a formal therapeutic relationship and maintains regular assessments, diagnostics, therapy, and/or prescription. Family Service Bureau of Newark, will be utilizing Health Insurance Portability and Accountability Act (HIPAA) protected software to ensure that your protected health information is secure from unauthorized access and that confidentiality is maintained. This document serves as a consent form for treatment via telehealth in general. In pages to follow are also our specific privacy practices.

1) You may elect to seek treatment in a more traditional, in-office visit with provider or another provider. Note that current evidence via rigorous studies has shown that treatment via telehealth is equivalent to face-to-face visits with a counselor / therapist / psychiatrist or Advanced Practice Nurse.
2) Pursuing treatment via telehealth is a decision made by you. If you choose to revoke your decision and pursue alternate treatment, you are able to withdraw your consent at any time. (Of course, we recommend discussing this decision with your provider first. Family Service Bureau of Newark also recommends establishing your next provider prior to termination to eliminate any gaps in treatment.
3) Unfortunate unpredictable consequences to telehealth can include but not limited to, disruption of transmission due to technology failure, interruption and / or breaches with confidentiality by unauthorized persons, and / or limited ability to respond to emergencies.
4) In the event that during a telehealth session there are technical difficulties resulting in service disruptions the provider and patient will reconnect via telephone for purposes of rescheduling.
5) There will be no recording of any online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and / or required by law.
6) It is understood that the privacy laws that protect the confidentiality of protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies. Such as, mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; or if mental / emotional or relapse issues are raised in legal proceedings.
7) If the patient is having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolves remotely, it may be determined that telehealth services are not appropriate and a higher level of care is required.
8) **Required Information at Every Visit**:
   Name, location, and telephone number of the patient at time of session. This is to ensure that our providers are aware of alternative means of treatment should an emergency occur.
   In the event of imminent danger, the provider is legally and ethically bound to report information to authorities, family members, or others, to minimize potential harm. For

this purpose, the client consents for a representative of Family Service Bureau of Newark to contact the following person in the event of an emergency:
Name:_____ Phone Number:_____
Address:_____ Relationship:_____ 9) Cancellation and Late Policy:

Each appointment is scheduled to begin and end on time. Please contact your clinician with at least 24 hours workday notice to cancel an appointment. Please keep in mind that missed appointments disrupt your progress in treatment.

10) Consent: The patient understands that he/she is consenting to a behavioral health evaluation and / or substance use treatment via telehealth. The patient understands that no results can be guaranteed, despite our best efforts to deliver care. The patient understands that they are able to ask questions about telehealth or any aspects of the evaluation and treatment at any time.

_____ I certify that I have read and understand the entirety of this document, titled "Telehealth Contract and Informed Consent."

By signing below, I am agreeing with this document, put forward by Family Service Bureau of Newark and I am also authorizing Family Service Bureau of Newark to use telepsychiatry for my evaluation and treatment.

1. Signature: _____
2. Name (Print): _____
3. Date: _____
4. Address: _____

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Insurance Billing Form

I,_____, give permission to the Family Service Bureau of Newark to bill (check one)

- ☐ Medicaid
- ☐ Medicare
- ☐ SAI/BHI
- ☐ Drug Court (DCI)
- ☐ Parole (SPB)

By my signature below, I hereby authorize assignment of financial benefits directly to Family Service Bureau of Newark. I understand that I am financially responsible for charges not covered by this assignment.

_____ _____
Client's Signature Print Name

_____ _____
Parent/Guardian's Signature Print Name

_____
Date

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Family Service Bureau of Newark

Attestation and Consent Release for County of Essex Chapter 51 Grant.

I, _____, hereby attest that I am a legal resident of Essex
(Client's Name)
County, New Jersey and I will provide documents verifying this attestation upon request.
_____I hereby attest that I do not currently have viable means of paying the full cost of my treatment services at Family Service Bureau of Newark, including (but not limited to) Medicaid or commercial insurance plans, which would prohibit of my care under the Chapter 51 Grant.

____I understand that this consent is valid for a period up to (1) year following the closure of my file with Family Service Bureau of Newark, and that I have the right to revoke my consent before that date. I understand that if I wish to revoke my consent, I must notify Family Service Bureau of Newark of that intention in writing. I understand that any information disclosed while this consent is in affect is done legally and cannot be challenged as a violation of relevant privacy laws.

____I understand that my signature and initials on this consent release indicate that I am voluntarily waiving my right to privacy in this contact and hereby give Family Service Bureau of Newark permission to disclose all relevant information to the County of Essex Chapter 51 Grant and or State authorities in order to facilitate my continued treatment until such time that other payment options are viable to cover the full cost of my services.

I, _____, hereby authorize Family Service Bureau of
(Client's Name)
Newark to communicate with all appropriate County and State Agencies and Offices as needed in accordance with the terms and provisions of the County of Essex Chapter 51 Grant. I have been informed of my payment options for treatment services at Family Service Bureau of Newark, including the option for sliding scale self-payment, and understand that in order for my care to be provided within my means to pay, Family Service Bureau of Newark must provide demographic and other information related to my treatment to the County of Essex Office of Addiction Services Chapter 51 and or other authorities at their request.

Client signature: _____Date: _____

Staff Signature/Credentials: _____Date: _____

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Family Service Bureau of Newark

Attestation and Consent Release for County of Hudson Chapter 51 Grant.

I, _____, hereby attest that I am a legal resident of Hudson County,

(**Client's Name**)

New Jersey and I will provide documents verifying this attestation upon request.

_____I hereby attest that I do not currently have viable means of paying the full cost of my treatment services at Family Service Bureau of Newark, including (but not limited to) Medicaid or commercial insurance plans, which would prohibit of my care under the Chapter 51 Grant.

____I understand that this consent is valid for a period up to (1) year following the closure of my file with Family Service Bureau of Newark, and that I have the right to revoke my consent before that date. I understand that if I wish to revoke my consent, I must notify Family Service Bureau of Newark of that intention in writing. I understand that any information disclosed while this consent is in affect is done legally and cannot be challenged as a violation of relevant privacy laws.

____I understand that my signature and initials on this consent release indicate that I am voluntarily waiving my right to privacy in this contact and hereby give Family Service Bureau of Newark permission to disclose all relevant information to the County of Hudson Chapter 51 Grant and or State authorities in order to facilitate my continued treatment until such time that other payment options are viable to cover the full cost of my services.

I, _____, hereby authorize Family Service Bureau of Newark to

(**Client's Name**)

communicate with all appropriate County and State Agencies and Offices as needed in accordance with the terms and provisions of the County of Hudson Chapter 51 Grant. I have been informed of my payment options for treatment services at Family Service Bureau of Newark, including the option for sliding scale self-payment, and understand that in order for my care to be provided within my means to pay, Family Service Bureau of Newark must provide demographic and other information related to my treatment to the County of Hudson Office of Addiction Services Chapter 51 and or other authorities at their request.

Consumer's signature: _____ Date: _____

Signature/Credentials: _____ Date: _____

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Financial Attestation Letter

Re:

_____

This letter is a written declaration regarding the above-named individual's financial status.

Please check the one condition that best describes your financial status.

□ I am currently employed by _____ (company's name) and getting paid _____ (gross work income per pay period) weekly/ bi-weekly/ monthly (please circle one payment period). The payment is cash, thus I am not able to provide any proof income.

□ I am currently unemployed and _____ (supporter's name) is providing financial assistance (housing/rent/food) for me during the time of my unemployment.

□ I am currently unemployed and do not have any income source.

_____ _____

Client Signature Date

Family Service Bureau of Newark
Newark Office: 274 South Orange Avenue, Newark, New Jersey 07103
Tel: 973-412-2056 Fax: 973-484-3452
West Hudson Office: 379 Kearny Avenue, Kearny, New Jersey 07032
Tel: 201-246-8077 Fax: 201-955-6165
www.newcommunity.org

Client Financial Responsibility

Positive verification of your coverage cannot always be made at the time of service. You will receive services with the understanding that in the event your coverage is not effective, you will be billed and held financially responsible for the services rendered. Payment is due before your next scheduled appointment or by the last day of the month, whichever date comes first. Failure to pay for services rendered will result in the agency discontinuing services, referring you to another facility, and closing your case.

If you are self-pay, your payment is due before the start of your session. Failure to pay for services rendered will result in the agency discontinuing services, referring you to another facility, and closing your case.

Payment is accepted via cash, money order, or Paypal.

I have read the above and understand my possible financial responsibility of services rendered and my signature below represents my acknowledgment of this understanding.

_____

Client Name

_____

Client Signature Date

_____

Staff Name

_____

Staff Signature Date

Family Service Bureau of Newark

Outpatient Service

Persons in Family	Federal Poverty Level	250% (Outpatient)	300%	350%	Above 350%
	If BELOW this amount	If BETWEEN this	If BETWEEN this	If BETWEEN this	AT OR ABOVE
	$35 Outpatient	$50 OP weekly fee	$65 OP weekly fee	$80 OP weekly fee	$95 OP weekly fee
	$70 IOP weekly fee	$105 IOP weekly fee	$140 IOP weekly fee	$175 IOP weekly fee	$200 IOP weekly fee
	Use funding monies only (if available)	Not eligible for funding Self-Pay Only	Not eligible for funding Self-Pay Only	Not eligible for funding Self-Pay Only	Not eligible for funding Self-Pay Only
1	$12,760	$12,760 to $31,900	$31,900 to $38,280	$38,280 to $44,660	$44,660
2	$17,240	$17,240 to $43,100	$43,100 to $51,720	$51,720 to $60,340	$60,340
3	$21,720	$21,720 to $54,300	$54,300 to $65,160	$65,160 to $76,020	$76,020
4	$26,200	$26,200 to $65,500	$65,500 to $78,600	$78,600 to $91,700	$91,700
5	$30,680	$30,680 to $76,700	$76,700 to $92,040	$92,040 to $107,380	$107,380
6	$35,160	$35,160 to $87,900	$87,900 to $105,480	$105,480 to $123,060	$123,060
7	$39,640	$39,640 to $99,100	$99,100 to $118,920	$118,920 to $138,740	$138,740
8	$44,120	$44,120 to $110,300	$110,300 to $132,360	$132,360 to $154,420	$154,420
For each addt'l person, add	4480				

Intake/ Assessment	**$100**	
Anger Management Group	**$180**	**6 Groups**
Parenting Group	**$240**	**8 Groups**
Initial Psychiatric Evaluation	**$130**	
Yearly Psychiatric Evaluation	**$130**	
Medication Management	**$75**	
Urine Screening	**$50**	
Urine Screening with EtG	**$75**	