Dr. Jessica Verdicchio, LCSW & Associates
10 Sycamore Avenue
Suite 2B
Ho-Ho-Kus, NJ 07423
862-621-9505

Welcome! This sheet is designed to offer information and answers to frequently asked questions.

1. **Appointments**: You must make an appointment to be seen. Most sessions run between 45 and 50 minutes.
2. **Emergencies**: In the event of an emergency, the best practice is to go to your local hospital emergency room where you can get immediate attention and medical assistance. You should also call the office and indicate that there is an emergency. I check my messages often and will get back to you as soon as possible. If I am on vacation and there is an emergency, you should also go to your emergency room. If possible, I will try to leave the name of a covering therapist.
3. **Cancellations**: Your session time is reserved for you. ***Please call/text at least 24 hours in advance if you need to change or cancel a scheduled appointment. Appointments that are not cancelled in a timely manner will be billed directly to you in their entirety.***
4. **The fee** for a therapy session is $200. Fees for sessions are required and expected at the end of each session. Payment can be made in cash, check or major credit card. **Checks should be made out to Positive Solutions, LLC.** I do not accept insurance. However, I will give you a bill at the end of each month that you can submit directly to your insurance company for reimbursement, if applicable.
5. Special services such as formal assessments and expert testimony are based on an hourly rate of $250. Any such fees will be discussed directly with you. I do not bill for short phone contacts (under 15 minutes). However, more extensive phone contact with you or others (i.e., schools, counselors, attorneys, etc.) will be billed directly to you.
6. **Confidentiality**: The Health Insurance Portability and Accountability Act of 1996 requires that our private health information is kept confidential at all times. Without your written permission, I cannot release any information about you. I will request permission in the event that someone else needs such information. You can revoke this authorization at any time.
7. If you are using insurance to pay (or be reimbursed for) for your treatment, you need to understand that insurance companies routinely request information in order to authorize treatment and pay claims. Thus, they are entitled to know your diagnosis as well as certain information regarding symptoms, health status, suicide/homicide risks, medications, substance use, and treatment goals. You should be aware that when you sign up for insurance coverage, you might have already been asked to sign a form wherein you agree that such information can be released for purposes of payment and treatment.
8. You should also note that there are certain exceptions to the privacy rules. By law, I am required to report the following situations: (1) suspected abuse of a child; (2) suicidal and/or homicidal threats; (3) certain law enforcement situations; (4) emergencies that involve legal investigations. Please note that according to state statutes governing social workers, adolescents over the age of 14 have a right to privacy with respect to sexual

activity, pregnancy issues, and substance use. In the event these are issues in the treatment of a given adolescent, I will make every effort to encourage a teen to share information with family members, especially if such sharing is not felt to be harmful to the child.

I appreciate the opportunity to work with you. If you have any additional questions, I will be glad to discuss these with you.

I have read the above policies and understand my financial obligations as well as the limits of confidentiality.______________________________(please initial)

I understand that I have to give written permission for the disclosure of private health information, and that there are some exceptions to this rule as noted above. __________________________(please initial)

Signature of client (if 14 or older)______________________Date:_____________________

Signature of Parent/Legal Guardian_____________________Date:_____________________

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INFORMED CONSENT FOR TREATMENT

I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with my therapist in a cooperative manner to resolve my difficulties.

I understand that during the course of my treatment, I may discuss material that is upsetting and that this might be a necessary part of the process.

I understand that records and information collected about me will be held or released in accordance with state and federal laws regarding confidentiality.

I understand that state law may require the reporting of all cases of abuse or neglect of minors and/or vulnerable adults.

I understand that state laws require reporting of all cases in which there exists a danger to self and others.

I understand that Jessica Verdicchio, LCSW & Associates (Positive Solutions LLC) may disclose records pertaining to my treatment to approved representatives of my insurance company and my primary care physician if such disclosure is required for claims processing, case management, authorization of sessions, coordination of treatment, quality assurance or utilization review purposes. I know I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken.

I have read and understand the above.

Signature of client (if 14 or older)________________________Date_______________

Signature of Parent/Legal Guardian______________________Date______________

Signature of Parent/Legal Guardian_____________________Date_________________

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List of Client's Rights - Distributed in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

You have the right to be treated with respect.

You have the right to fair treatment, regardless of race, religion, gender, ethnicity, age, disability, or source of payment.

You have the right to have treatment and other member information kept private and released only with your written permission.

You may revoke written consent to release information at any time.

Records can only be released without permission in the event of an emergency or if required by law- Examples include: public health activities, civil or criminal proceedings, law enforcement, medical examiners, research (if the proper requests have been completed) or reports of suspected maltreatment or domestic violence as required by law.

You have the right to information provided in a language you can understand.

You have the right to an easily understood explanation regarding your diagnosis and treatment.

You have a right to know about various treatment choices.

You have a right to participate in treatment plan and to know about what information is being shared with your insurance company.

You have a right to see your medical records.

All information about you that is transmitted either electronically, on paper, by fax or by phone is safeguarded by limiting access to data.

I HAVE RECEIVED A COPY OF THIS DOCUMENT:

NAME________________________________DATE__________________

PARENT/LEGAL GUARDIAN______________________DATE____________________