



SUMMIT
MEDICAL
GROUP

Summit Medical Group
Behavioral Health & Cognitive Therapy Center
654 Springfield Avenue • Berkeley Heights, NJ 07922
908-508-8909 • www.smgnj.com

In an effort to reduce our current delay with initial and follow up appointments we are currently in the process of increasing our Pediatric Therapy staff.

We appreciate your patience and are looking forward to working with your family.

Thank you
BHCTC Pediatric Staff



Behavioral Health & Cognitive Therapy Center Office Information and Patient-Therapist Agreement

Welcome to Summit Medical Group's Behavioral Health and Cognitive Therapy Center (BHCTC). We thank you for choosing us for your counseling needs. This Office Information and Patient-Therapist Agreement (Agreement) includes important information about BHCTC's services, office policies and expectations. **It is important that you read this Agreement carefully and raise any questions you may have about it with your clinician.** When you sign this Agreement, it creates an actual agreement between you and your clinician and both you and your clinician are expected to act in accordance with all of its terms, and that your clinician will expect you to do the same. You may revoke this Agreement in writing at any time; however, you may still be held to the Agreement's payment obligations even though you have decided to revoke it. Please read the following information carefully and feel free to ask your clinician any questions during your meeting together. After reading this Agreement please sign it at the bottom and give it back to the receptionist.

Counseling and Psychotherapy Services

Counseling and psychotherapy are treatments that help patients confront issues and feelings that are causing them problems. These treatments call for an active effort on your part during the sessions and may require you to work on issues between sessions. Treatment can have many benefits and some side effects that may be unpleasant. The benefits may include reduced feelings of anxiety and depression, better relationships with others, and solutions to specific problems. However, because treatment often involves discussing unpleasant parts of your life, you may experience temporary feelings like frustration, anger, guilt, and sadness. People who usually get the most benefit from treatment are those that keep their appointments regularly and are committed to making changes in their lives. The BHCTC cannot guarantee how much benefit you will personally experience.

Sessions

Your first session with your clinician will involve an evaluation of what problems appear most important to work on and what treatment needs you have. By the end of this first evaluation time, your clinician will give you their thoughts about your work together and what treatment they feel will be most helpful. This first session will evaluate your needs and determine if your clinician and the BHCTC is right for your treatment. This initial session will also help you to determine if you feel comfortable receiving treatment at the BHCTC.

If you and your clinician choose to begin treatment together, you will be scheduled for treatment sessions at a length and frequency determined by you and your clinician. ***The goal***

of treatment is to get you feeling and functioning better as efficiently as possible and we therefore limit the total number of sessions to approximately 12 or three-months of weekly therapy sessions. (For a better understanding of BHCTC’s approach please read the “What is Cognitive Behavioral Therapy” handout in this packet).

You will receive the best benefit from treatment if you come to your appointments regularly. If you must cancel an appointment, this Agreement represents your promise that you will do so at least 24 hours in advance of your scheduled time. If you do not cancel 24 hours in advance, the BHCTC will need to charge you for a missed session because your clinician will have reserved that treatment time for you and will be unable to use that time to see any other patient. A missed appointment can not be billed to your insurance carrier, which means that you will be responsible for paying the BHCTC in full a \$100 cancellation fee for the missed appointment. The BHCTC recognizes that emergencies or other unplanned events do arise that can not be helped (flat tires, sick children, family emergencies), so this Agreement allows you to cancel one (1) appointment less than 24 hours in advance within any 6 month period without any charge to you. If you cancel more than that, you understand and agree that BHCTC can bill you \$100 for each missed appointment.

We try very hard to accommodate our patients and to see them in a timely manner; however, there is often a waiting list for individuals seeking treatment due to a lack of available session times. Therefore, if you miss 4 appointments where you fail to give 24 hours cancellation notice within any 12 month period you may be dismissed from BHCTC. You are only eligible to reapply for treatment after 12-months has passed from the time of your dismissal.

Working with your Physician

Many of our patients have been referred to us by their Summit Medical Group (SMG) physicians and/or other physicians not affiliated with SMG. We find that contacting these physicians about your treatment ensures that your overall care is uniform and effective. It is our position that notifying your treating physician about the treatment BHCT is providing to you, and having your physician give us background about your medical history, improves your overall treatment. If your physician is an SMG provider, by signing this, you are authorizing and permitting the BHCT to contact your physician by the method determined by BHCT (e.g., phone, letter). If you are an SMG patient, please note that although the BHCTC and SMG share an electronic health record system, your session notes—the notes written by your clinician that reflect the things you have discussed during your sessions—are not accessible by SMG physicians and personnel. SMG physicians will, however, have access to a list of medications the BHCTC prescribes.

If your physician is not affiliated with SMG, the BHCTC may have you sign the Consent to Share Information Form to discuss your treatment with your provider. The BHCTC may also attempt to contact them by letter or phone stating that we have begun treatment with you. We will also ask them to contact us if they have any questions or concerns about your treatment. **If there is any specific information you do not want your treating physician to know, please discuss this with your treating clinician.**

Medication Appointments

If your clinician believes you would benefit from psychiatric medications he/she will either speak to your treating physician, refer you to a local psychiatrist or make an appointment with the BHCTC psychiatrist for a medication evaluation. We require that you are in active psychotherapy to utilize our psychiatrist. Treatment with our psychiatrist is considered short-term and once you are stabilized on your medication you will be referred back to your treating physician who will monitor your medication and provide refills.

Professional Fees

The BHCTC's initial intake assessment fee is \$255. The 45-minute follow-up session fee for treatment is \$192. We also charge the \$192 fee (or break down of the hourly cost for periods of less than 45 minutes) for other services including report writing, attending authorized meetings with other professionals, preparation of records or treatment summaries, telephone conversations lasting longer than 15 minutes, and time spent in any other service you request of us. This fee for non-session services may or may not be reimbursed by your insurance company. If you become involved in any legal proceedings that require our participation, you will be required to pay for our professional time even if we are called to testify by another party. Because of the time-consuming nature of legal involvement, we charge \$600 per hour for preparation and attendance at any legal proceeding. These services are usually not reimbursed by your insurance company.

Billing and Payments

This Agreement requires that you pay for each session you have at the BHCTC at the end of each session. Where applicable, we will bill the insurance company for you, but you are required to pay your co-payment and any deductible at the end of each session. As a courtesy, we will check with your insurance carrier and will make reasonable attempts to determine what you will need to pay at each session; however, we can not guarantee that the information provided to us is correct and you are ultimately responsible for determining your insurance coverage and for paying the BHCTC for treatments provided to you that are not covered by your insurance plan. **By signing this Agreement you agree that you will pay any outstanding amounts due and owing to the BHCTC.** In circumstances of financial hardship, please contact SMG's business office to discuss payment options. If you have not made payments on your account within 2 scheduled sessions, and no payment arrangements have been made, the BHCTC reserves the option to use legal means to obtain payment from you. This may involve hiring a collection agency or going to small claims court.

Insurance Reimbursement

If you have health insurance, your behavioral health treatments may be covered in whole or in part. The BHCTC will assist you in determining your insurance coverage and will help you fill out any forms needed. Many managed care plans often require an authorization before treatment can begin. You may be required to contact your insurance company to obtain this authorization and/or receive it from your primary care physician.

Many managed care plans limit counseling and therapy services to short-term treatment designed to work out specific problems that prevent people from living and working as they normally do. As this is the BHCTC's model of treatment, this often works out well. Where necessary, we may request more sessions from the managed care plan. In order to do so, we are typically required to complete the insurance company's forms which may include providing your diagnosis, the reasons you have sought treatment from the BHCTC, the symptoms you are suffering, and how long we believe treatment will or should continue. The information provided will become part of the insurance company's files. Insurance companies are obligated to keep this information confidential; however, please note that the BHCTC has no control over the handling of this information by the insurance company.

If you receive treatment from one of our NJ Licensed Psychologists, your insurance company may request that you authorize the psychologist to disclose certain confidential information in order to obtain insurance coverage benefits for these services. This disclosure can occur only if it is pursuant to a valid authorization and the information is limited to: 1) administrative information (name, age, sex, fees, dates, nature of sessions, etc.); 2) diagnostic information; 3) the status of the patient (voluntary/involuntary; inpatient/outpatient); 4) the reason for continuing psychological services (limited to an assessment of the current level of functioning and the level of distress both rated as mild, moderate, severe or extreme); and 5) a prognosis, limited to the estimated minimal length of treatment. If the Insurance Company has reasonable cause to believe that the psychological treatment in question may not be usual, customary or is unreasonable, it may request an independent review of such treatment by an independent review committee.

While a lot can be accomplished in short-term therapy, some people feel they need more services after their insurance benefits end. If this is the case with you, we will discuss what our fees are and the best way for you to arrange payment in order to receive continued treatment. If your insurance company does not allow us to see you after your benefits end, we will be happy to assist you in finding another therapist who will work well with you.

It is also important to remember that you always have the right to pay for your treatment yourself to avoid any insurance issues discussed above.

Contacting Us

You may contact the BHCTC office during regular business hours and during our evening hours to make or change appointments. Our staff is available to assist you with insurance questions. Our clinicians make all reasonable efforts to return telephone calls to patients promptly. If you have an emergency or crisis and are unable to reach your clinician, please do not hesitate to call 911, your local hospital's emergency room or a crisis center such as Overlook Hospital's Crisis Center (908-522-3586) for immediate help.

Professional Records

HIPAA requires that we maintain the confidentiality of "Protected Health Information" (PHI). You are permitted to examine or request a copy of your clinical record upon submitting a

written request to do so in accordance with HIAA. Please note that there are some exceptions to release of these records and we will promptly advise you if we are unable to release these records to you upon receipt of your signed authorization. As behavioral health records may be misinterpreted and/or cause undue stress to patients, we strongly encourage you to initially review them in your clinician's presence, or have them forwarded to another mental health professional so you can discuss the contents with that professional. We charge a copying fee for these records, as is permitted by New Jersey regulation.

Patient Rights

HIPAA provides you with several expanded rights with regard to your Clinical Records and disclosures of protected health information (PHI). These rights include: requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of PHI that you have neither consented to nor authorized; the location to which PHI disclosures were sent, recourse to any complaints you have about the policies and procedures we have pertaining to the care of your PHI, the right to a paper copy of this Agreement (the attached Notice form) and our privacy policies and procedures. Our staff is happy to discuss any of these rights with you.

Minors

If you are under 18 years of age, please be aware that the law provides your parents with the right to examine your treatment records, with certain exceptions. Specifically, New Jersey law provides that where a minor patient is between the age of 14 and 18, treatment records by a licensed psychologist or a social worker may only be released where both the patient and the patient's parent or legal guardian has signed an authorization. A parent or legal guardian of a minor patient treated by a licensed psychologist or social worker who is under the age of 14 may access medical records without the minor patient's authorization.

It is our policy to ask minor's parents to agree to give up this right so that our work together may be more confidential. If they agree, we will only give them very general information about the minor's treatment or any information the minor patient and the clinician agree upon.

If you are a divorced or single parent of a minor, we require that both parents consent and are involved with the minor's treatment. This is to ensure that treatment goals are agreed upon and can be maintained when the minor is with either parent. **Even if you refuse to have your child's other parent notified of treatment, your child's other parent may be entitled to request and receive a copy of the minor child's treatment records where permitted by New Jersey law.** If you are concerned about the release of these treatment records to your child's other parent, please speak with your child's clinician. In the event the other parent's parental rights have been terminated by the Court, please provide a copy of the Court's Order to ensure that your child's records are not released to the terminated parent. The BHCTC reserves the right, in its sole discretion, to refuse to treat a child in cases where the BHCTC determines that both parents consent is necessary.

Confidentiality

In general, our work together is private and the law protects your privacy. In most situations (and subject to certain exceptions), we can only release information about your treatment to others if you sign a written Authorization Form that meets certain legal requirements imposed by HIPAA and state laws and regulations. There are other situations that require only that you provide written, advance consent (Please see the Notice of Privacy Practice for more information about these situations).

While such situations are unusual in our practice, we are required to reveal otherwise confidential information about your treatment in circumstances such as the following:

- If we have reasonable cause to believe that a child has been subject to abuse, we must report it to the Division of Youth and Family Services. Once such a report is filed, we may be required to provide additional information.
- If we have reasonable cause to believe that a vulnerable adult is the subject of abuse, neglect or exploitation, and we believe that the disclosure is necessary to prevent serious harm to that adult or other potential victims, we will report the information to the county adult protective service provider. Once such report is filed, we may be required to provide additional information.
- If a patient communicates a threat, or if we believe the patient presents a threat of imminent serious physical violence against a readily identifiable individual, we may be required to make protective actions. These actions may include notifying the potential victim, contacting the police, or seek the patient's hospitalization.
- If we believe a patient presents a threat of imminent serious physical harm to him/herself, we may take various protective actions.

Clinician Supervision

In order to ensure that you and/or your child receive treatment that is of the highest quality, our clinicians are subjected to both individual and group supervision to discuss certain patient matters related to patients they treat. This helps ensure that your clinician is utilizing the most effective therapeutic approach. All clinicians at the BHCTC are strictly bound by confidentiality requirements related to the patients they treat, as well as patients discussed in supervision.

Feel free to discuss any concerns you have with our staff or your clinician. We will be happy to discuss the matter with you or refer you for legal advice if we can not adequately answer your questions.

Again, we want to thank you for choosing SMG and the BHCTC for your treatment needs. We hope the information provided in this Agreement makes you an informed consumer of behavioral health services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Signature

Date

Print Name



**Behavioral Health &
Cognitive Therapy Center**

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www.summitmedicalgroup.com

PATIENT NOTICE OF CANCELLATION POLICY

THIS NOTICE DESCRIBES IN DETAIL THE CANCELLATION POLICY OF THE SUMMIT MEDICAL GROUP BEHAVIORAL HEALTH AND COGNITIVE THERAPY CENTER. PLEASE REVIEW IT CAREFULLY.

I. What This Is

This notice describes in detail, the cancellation policy of the Behavioral Health and Cognitive Therapy Center (BHCTC)

II. Our Policy

We require patients to keep all scheduled appointments. If you must cancel an appointment you must do so **24 hours prior** to the appointment time. If you do not cancel **prior to 24 hours** the BHCTC will charge for that session.

III. Why do we have this policy?

Patients best benefit from treatment when they come on a regular basis. Furthermore, your Clinician has reserved that time for you. If you do not give enough notice of cancellation the Clinician will be unable to use that time to see any other patient.

IV. What if I have an emergency?

The BHCTC of course recognizes that emergencies or other unplanned events do arise (i.e. flat tire, sick children, family emergencies, etc.), that is why we allow you to cancel **one (1)** appointment less than **24 hours** in advance without any charge to you, **within any 6 month period**. However, if you cancel more than that you will be billed for each missed appointment.

V. How much would I be billed if I miss more than two appointments? Why?

You will be billed **\$100**. A missed appointment cannot be billed to your insurance carrier, which means you will be responsible for paying the full **\$100** cancellation fee for the appointment.

People who usually get the most benefit from treatment are those that keep their appointments regularly and are committed to making changes in their lives. We look forward to continued treatment with you, as we aim to help you feel better and lead more productive lives.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS NOTICE AND AGREE TO ITS TERMS.

Signature

Print Patient Name

Date of Evaluation: ___ / ___ / ___

MRN: _____

1. Information about the child:

Last Name: _____ First Name: _____ Initial: _____

Date of birth: _____ Gender: Female Male

Ethnicity/Race: _____ Language of the home: _____

2. Information about the child's parent or guardian:

Last Name: _____ First Name: _____ Initial: _____

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

3. Reason for Assessment

State purpose of assessment as described by referent and/or youth and family.

4. Youth's goal for assessment (if age appropriate)

Describe what youth hopes to learn, communicate, and/or initiate with this assessment.

5. Family/caregiver's goal for assessment

Describe what family/caregiver hopes to learn, communicate, and/or initiate with this assessment.

6. Developmental and Physical Health

a. Physical Health

Primary Care Physician: _____
(Name) (Phone Number)

i. Please describe youth's current health according to him/her and his/her primary caregiver:

b. Developmental History

i. Pregnancy History

Did mother have access to prenatal care? Yes No Info N/A

Was youth exposed to toxins before birth? Yes No Info N/A

If yes, specify type (i.e., prescription medications, illegal substances, etc.):

Length of pregnancy: Pre-term Term Post-term

Complications at birth: _____

Temperment as an infant: _____

ii. Developmental Milestones

Crawling: within normal limits Not within normal limits

If not within normal limits please explain: _____

Walking: within normal limits Not within normal limits

If not within normal limits please explain: _____

Speaking single words: within normal limits Not within normal limits

If not within normal limits please explain: _____

Speaking sentences: within normal limits Not within normal limits

If not within normal limits please explain: _____

Toilet training:: within normal limits Not within normal limits

If not within normal limits please explain: _____

Separating from caregiver: within normal limits Not within normal limits

If not within normal limits please explain: _____

iii. Parental Concerns

Please note any parent/guardian concerns during the 0-5 years: _____

c. Significant Developmental Events

i. Has the child ever been treated for a serious injury, including a head injury?
(Please provide age, intervention, and outcome if appropriate) Info not available

ii. Has the child ever been treated for lead poisoning?
(Please provide age, intervention, and outcome if appropriate) Info not available

iii. Has the child ever had a seizure or been treated for a seizure?
(Please provide age, intervention, and outcome if appropriate) Info not available

7. Family Functioning

Family composition

Please provide information about who lives in the home with youth.

Name: _____ Relationship to youth: _____ Age: ____ Gender ____

Does this family member have:

Mental Health or substance abuse involvement Legal involvement

Please explain if appropriate: _____

Name: _____ Relationship to youth: _____ Age: ____ Gender ____

Does this family member have:

Mental Health or substance abuse involvement Legal involvement

Please explain if appropriate: _____

Name: _____ Relationship to youth: _____ Age: ____ Gender ____

Does this family member have:

Mental Health or substance abuse involvement Legal involvement

Please explain if appropriate: _____

Name: _____ Relationship to youth: _____ Age: ____ Gender ____

Does this family member have:

Mental Health or substance abuse involvement Legal involvement

Please explain if appropriate: _____

Name: _____ Relationship to youth: _____ Age: ____ Gender ____

Does this family member have:

Mental Health or substance abuse involvement Legal involvement

Please explain if appropriate: _____

8. Educational Functioning

- i. Detail current school functioning:
Include level of inclusion, activities, favorite subject, etc.
-
-
- ii. Detail past school functioning:
Include difficult and/or repeated grades, periods of suspension, periods of “home instruction,” etc.
-
-
- iii. Detail Child Study Team involvement:
-
-
- Classification: _____ Child Study Team Case Manager: _____

Please answer the following questions when appropriate for your child.

9. Legal Involvement/History

- a. Current Legal Charges
 Yes No Please Explain: _____
- b. Prior Legal Charges
 Yes No Please Explain: _____

10. Treatment History

Document the history of all treatment past and present:

- a. Behavioral health treatment
- i. List past and present treatment youth has participated in:
- | Type of treatment | Agency/provider | Dates (or estimation) of service | Estimated helpfulness of treatment and reason for termination |
|-------------------|-----------------|----------------------------------|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
- ii. Barriers to behavioral health treatment:
Be specific about challenges that impact(ed) treatment: transportation, finances, negative rapport, lack of involvement, other disruptions, etc. _____
-
- b. Medication therapies
- i. List medications tried in the past:
- | Medication | Dosage | Frequency | Youth’s age and response to medication | Reason for changing or terminating medication |
|------------|--------|-----------|--|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

ii. **Barriers to behavioral health treatment:**
 Be specific about challenges that impact(ed) treatment: transportation, finances, negative rapport, lack of involvement, other disruptions, etc. _____

iii. List current medications:

Medication	Dosage	Frequency	Youth's response to medication
_____	_____	_____	_____
_____	_____	_____	_____

iv. **Barriers to behavioral health treatment:**
 Be specific about challenges that impact(ed) treatment: transportation, finances, negative rapport, lack of involvement, other disruptions, etc. _____

c. **Substance abuse therapies**

List past and present substance abuse treatment youth has participated in:

Type of treatment	Agency/provider	Dates (or estimation) of service	Estimated helpfulness of treatment and reason for termination
_____	_____	_____	_____
_____	_____	_____	_____

v. **Barriers to behavioral health treatment:**
 Be specific about challenges that impact(ed) treatment: transportation, finances, negative rapport, lack of involvement, other disruptions, etc. _____

11. Youth's present challenges

a. What are present challenges for the youth?

Challenge	Is this challenge a reason for current assessment?
1 _____	<input type="checkbox"/> Yes
2 _____	<input type="checkbox"/> Yes
3 _____	<input type="checkbox"/> Yes

b. What strategies have been attempted for the above 3 challenges?

Strategy attempted:	Family/youth's estimation of helpfulness of strategy
1 _____	_____
2 _____	_____
3 _____	_____

12. Mental Status

a. Impulse Control

- Controlled with prompt/cues/support
- Minimal control
- Over-controlled
- If minimum control, does it pose a risk to: Self Others

b. Suicidal Ideation

- Ideation history
- Settling of affairs

- Viable plan
 - Previous attempt/s
(Please detail below)
-

- Current ideation
 - Available means
(please detail below)
-

c. Hostile Intent

- Previous
intimidation

- Viable plan
 - History of violence
(Please detail below)
-

- Current intent
 - Available means
(please detail below)
-

FOR PATIENTS 11 AND OLDER ONLY

**A Survey From Your Healthcare Provider —
PHQ-9 Modified for Teens**



Name _____

Clinician _____ Date _____

**Instructions: How often have you been bothered by each of the following symptoms during the past two weeks?
For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.**

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

10. In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes? Yes No

11. If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?
 Not difficult at all Somewhat difficult Very difficult Extremely difficult

12. Has there been a time in the past month when you have had serious thoughts about ending your life? Yes No

13. Have you **ever**, in your **whole life**, tried to kill yourself or made a suicide attempt? Yes No

FOR OFFICE USE ONLY Score _____

Q. 12 and Q. 13 = Y or TS = ≥11

DASS₂₁

Name:

Date:

Please read each statement and circle a number 0, 1, 2 or 3 that indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of the time
- 3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Summit Medical Group

ACKNOWLEDGMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE

I. Acknowledgment of Privacy Practice Notice

I have received a copy of the Summit Medical Group's Notice of Privacy Practices.

Patient's Name

Date of Birth

Signature of Patient/Parent/Guardian

Date

II. Designation of Certain Relatives, Close Friends and Other Caregivers

INITIAL

UPDATE

I agree that Summit Medical Group may disclose certain portions of my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to my health care. In that case, Summit Medical Group will *disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.*

I wish to make no designation at this time.

Signature of Patient /Parent/Guardian

Date

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of Summit Medical Group's making the limited disclosures described above. (I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.)

Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

Signature of Patient /Parent/Guardian

Date

Please Return to Staff Member or Mail to: Summit Medical Group - HIPAA Coordinator , 1 Diamond Hill Rd, Berkeley Heights, NJ 07922



Behavioral Health and Cognitive Therapy Center

908-508-8909

654 Springfield Avenue, Berkeley Heights, NJ 07922

www.summitmedicalgroup.com

Billing and Payments Agreement

- This Agreement requires you to pay for each session you have at the Behavioral Health & Cognitive Therapy Center (BHCTC) at the end of each session.
- If you have insurance, we will bill the insurance company for you, but we will expect you to pay your co-payment and any deductible at the end of each session.
- As a courtesy, we will check with your insurance carrier and will determine to the best of our ability what you will need to pay at each session.
- **However, because behavioral health insurance tends to be complex we can not guarantee that the information provided to us is correct. As a result, you are responsible for determining your insurance and for paying the BHCTC for treatments that it has provided or are not covered by your insurance plan.**
- By signing below you are agreeing that you will pay any outstanding amounts due to the BHCTC. In circumstances of financial hardship, or if we do not accept your insurance, the BHCTC may have you contact Summit Medical Group’s business office to arrange for a payment installment plan.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

Signature Patient/Parent/Guardian

Print Patient Name



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Cognitive Therapy Center**
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Questions & Answers About Child/Adolescent Therapy

Q: What should my child and I expect at our first session?

When your child begins therapy, your therapist will meet with each of you, separately and/or together to gather as much information as possible, in order to assess what kinds of problems your child is experiencing. This information will be gathered by interview and by using questionnaire forms. At the end of your child's initial evaluation your therapist will discuss with you the frequency and modality of treatment that will best suit your child's needs.

Types of Therapy:

Cognitive-Behavioral Therapy

Q: What is cognitive-behavioral therapy (CBT)?

CBT focuses on how a child thinks and what a child does. CBT is primarily concerned with the present and future rather than past events or unconscious motives. The therapist decides along with you and your child what behaviors and thinking patterns need to change.

Cognitive-behavioral therapy is different from other kinds of therapy in several ways. It is:

- Goal-oriented. It helps you and your child set goals, plan ways to achieve those goals, and check progress.
- Problem-focused. The therapist you and child work together to identify problem areas and what exactly needs to change.
- Active. CB therapists do not just sit back and silently nod as the child talks. They will actively listen to the child and ask meaningful questions.

CBT typically requires you and your child to complete weekly homework assignments. This helps the child change behaviors between sessions. It also cuts down on the number of sessions needed.

Q: What happens during a typical therapy session?

A family member who thinks there is a problem usually brings children and teens to therapy. Children often blame their problems on family members, teachers, or peers. They may not see how talking to a therapist about their problem will help. Therapists who specialize in working with children and teens are skilled in finding out what the child wants and needs. For example, do they want to stop being picked on by their peers? Get along better with family members? Feel better about themselves? This helps the therapist to motivate the child.

Behavioral Therapy

Q: What is behavioral therapy?

This type of therapy is very structured and goal oriented. It starts with what you and your child is doing now, and then helps both of you change your behavior. Behavioral therapists may use techniques such as:

- Exposure therapy or desensitization. First the child learns ways to relax. Then they will learn to face their fears while they practice these relaxation skills.
- Role-playing. This may help your child become better at solving conflict with peers.
- Self-monitoring, or keeping a log of their daily activities/behaviors. This may help identify which behaviors are causing your child problems.

Family Therapy

Q: What is family therapy?

Family therapy is a form of treatment that involves all members of the family rather than working with one person alone. It helps the whole family to make changes. Many child and teenage problems improve a great deal when the family changes how they deal with the child. By improving family relations, emotional or behavioral problems are also improved.

In therapy the family will:

- Join in the treatment sessions.
- Seek to understand what family behaviors may help or hinder their child.
- Learn different family behaviors that will help the child to make positive changes.

Q: What happens during family therapy sessions?

For each session the therapist will ask to see all or some of the family members. At times, the therapist may ask to just see the parents or just the children. Who is asked to attend may change based on what the issues are and who is most involved with them. With children younger than 11 or 12, the therapist may divide sessions into individual time with children and time with parents. At the start of each session the therapist will check on what has happened around issues which are the focus of treatment. Next the therapist will choose 1 or 2 things to focus on. The therapist may ask family members to role-play how they talk about things or how they behave at home. The therapist will help the family understand the way they talk and act with each other. The family learns which behaviors are healthy and which are not. The therapist will come up with a plan for the family to change those interactions that are not helpful. This may involve practice in the session or assigned homework to practice out in the real world.

Play Therapy

Q: What is play therapy?

Play therapy uses many kinds of toys, games, and drama to help children learn to deal with frightening feelings/events and different emotions. Play therapy helps children express themselves without words. Play therapy can be helpful for children of all ages but is most often used for children between the ages of 3 and 12. Sometimes play therapy can involve the whole family. Usually, therapists work only with your child and regularly report their findings to you. They will also suggest how you can best support your child.

Q: What happens during play therapy sessions?

- The therapist will create a safe and interesting environment for your child. This helps the child to feel comfortable and to be willing to explore. Your child may use dolls, action figures, modeling clay, art supplies, or other toys to express themselves and work on their problems. The therapist will observe how your child plays with the toys, the feelings expressed, and any aggressive actions.
- In time, your child learns how to express feelings more appropriately and becomes less negative and less angry. Your child feels more positive and starts to see people and events in a more balanced way. It also may help your child handle difficult situations such as, peer conflict and bullying in a more positive way.

*Portions of the above information were taken from The Summit Medical Group Live Well Library.